

UNIVERSITY OF BAHRAIN

**College of Health
and Sport Sciences**



**Department of
Nursing**

An Exploratory Qualitative Study of Oncology Nurses' Experience in Providing Care for Terminally Ill Patients in Salmaniya Medical Complex in Bahrain

**In Partial Fulfillment of the Requirement for the Degree of Master of
Science in Adult Health Nursing**

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Defence Committee's Approval

University of Bahrain
Deanship of Graduate Studies
and Scientific Research



جامعة البحرين
عمادة الدراسات العليا والبحث العلمي

Thesis Discussion Committee Decision

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The Discussion Committee met on ___ 16th April 2023_ In Microsoft team meeting. Upon discussing the student whose details are stated above in public, the discussion committee recommends the following:

The student is awarded a grade ___A___ in the thesis subject.

☐ Without making any changes to the thesis.

☒ After making the modifications attached with this decision.

Discussion Committee Members Approval:

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Abstract

Oncology nurses are essential in palliative care for cancer patients, especially at end-of-life stages. Caring for terminally ill cancer patients is stressful, accompanied by negative and positive feelings, but oncology nurses have an unavoidable responsibility. However, little is known about oncology nurses' experience in the Kingdom of Bahrain caring for terminally ill cancer patients in their final weeks or days. This study aimed to explore the experience of oncology staff nurses in providing care for terminally ill patients in the Kingdom of Bahrain, and the research answered those questions: (a) What is the experience of oncology staff nurses in providing care for terminally ill patient? And (b) How does the experience of oncology nurses in providing care to terminally ill patients impact the quality of care provided to patients? A qualitative descriptive, interpretive exploratory research design was utilized for this study to explore the experience of oncology staff nurses with terminally ill patients, conducted in two hospital settings at Salmaniya medical complex (inpatient & outpatient) oncology department. The data were collected using a purposive sampling to include 15 oncologist nurses whose experiences were across various characteristics with different professional roles and qualifications. The data were collected through 15 semi-structured interviews guided by a semi-structured interview protocol. Data were analyzed using Braun and Clarke's 2006 thematic analysis model without pretexting. The research findings revealed three key themes that emerged from thematic analysis: (1) exhausting versus rewarding experienced feelings; (2) Factors influencing Nursing care; (3) Moral Distress. End-of-life care in the Kingdom of Bahrain reflects and has been influenced by primary total nursing care. Oncology nurses reported suffering but also benefiting from their experiences. End-of-life cancer care training is needed and urged by oncology nurses, especially those younger and less experienced. Also, future studies are mandated to explore interventions to help overcome the challenges that are impeding nurses from providing high-quality care for terminally ill patients in the kingdom of Bahrain.

Keywords: Terminally ill; Terminal Care; palliative care; an oncology nurse.

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Dedication

I dedicate my study work to my family, especially my fabulous kids (Ebrahim, Fatima, Salman, and Amna). A special feeling of gratitude to my loving parents and husband, who were always there for support and encouragement.

I also dedicate this study to my Nurse Supervisor Layla Ebrahim who has supported me throughout the process.

I hope this study helps improve and enhance the oncology nurse experience in the kingdom of Bahrain and allows further opportunities for future studies.

LIST OF ABBREVIATIONS

AACN	: American Association of Colleges of Nursing
ACS	: American Cancer Society
ANA	: American Nurse Association
APNs	: Advanced Practice Nurses
CINV	: Chemotherapy-Induced Nausea and Vomiting
CF	: Compassion fatigue
DT	: Dignity Therapy
DNA	: Deoxyribonucleic Acid
EoL	: End-of-Life
EMR	: Eastern Mediterranean Region
GR	: Glucocorticoid Receptor
GH	: Governmental Hospitals
IC R	: Integrated Circuit Record
IPRCC	: Interagency Pain Research Coordinating Committee
MoH	: Ministry of Health
NSAIDs	: Non-Steroidal Anti-Inflammatory Drugs
ONPs	: Oncology nurse practitioners
QoL	: Quality of Life
PC	: Palliative Care
SMC	: Salmaniya Medical Complex
SES	: Socioeconomic Status
STS	: Secondary Traumatic Stress
SHRs	: Steroid Hormone Receptors

UoB	: University of Bahrain
VIP	: Very Important Person
VTE	: Venous Thromboembolism
WHO	: World Health Organization

Chapter I

Introduction

CHAPTER ONE: INTRODUCTION

1.1 Introduction

This chapter introduces a snapshot of the study background (Section 1.2), which includes a feature of terminally ill patients, their suffering, treatment options and role of palliative care, and oncology nurses' role and obligation in this stage. The following section (1.3) describes the study context, including general information about Bahrain, its healthcare services, oncology care, vital statistics about the nurse workforce and cancer incidents. This chapter also presents the aim and objectives of the study and research questions (See Sections 1.4, 1.5, 1.6 and 1.7). The significance of the study will be explained in Section 1.8, ended up with a chapter summary in Section 1.9.

1.2 Background of the Study

Cancer is a group of diseases in which cells split continuously and excessively, and genomic instability is the hallmark of several malignancies with the increasing accumulation of deoxyribonucleic acid (DNA) damage (Matthews et al., 2022; Huang & Zhou, 2021). The latter disease process is called metastasizing and is a significant cause of death. Also classified and described as Stage IV cancer, end-stage cancer, or terminal stage, which involves primary source, body fluid, lymph nodes, and other body organs (WHO, 2019; Patel et al., 2019).

Cancer is also considered a leading cause of death worldwide, accounting for nearly 10 million deaths in 2020 (WHO, 2022). Even though it is the second leading cause

of death, universally reported an estimated 9.6 million deaths or one per six deaths in 2018. The incidents by cancer types, lung, prostate, colorectal, stomach, and liver cancer, are the most communal types of cancer in men, while breast, colorectal, lung, cervical, and thyroid cancer are the most common (Ferlay et al., 2020).

1.2.1 Terminally Ill Patient Suffering

Oncology patients at the terminal stage suffer in various ways, physically and emotionally. On one hand, physical suffering (e.g., pain, fatigue, nausea, vomiting, dyspnea, depression, lethargy). Breathlessness is communal and is likely to affect at least 24% of cancer patients who do not have predisposing factors such as intrapulmonary pathology and as many as three in five patients with thoracic cancers (Ekström et al., 2016). Fatigue is probably to affect 50%–90% of cancer patients, with few effective pharmacological therapeutic interventions currently available (Meriggi, 2014). On the other hand, emotional suffering includes loss of meaning and autonomy, feeling of being a burden, fear, and worry about the future (Gramling et al., 2019).

Psychological suffering in the terminal stage translated through their desire for death was associated with depression and anxiety, 18.3% recognized occasional temporary thoughts, and 12.2% reported a genuine desire to die (Wilson et al., 2016). Furthermore, the desire for death is common among patients with advanced, life-threatening illnesses (Hudson et al., 2006).

1.2.2 Treatments Options and Role of Palliative Care in End-of-Life Care Stage

Treatment modalities and technologies for end-stage cancer vary and are advanced, e.g., palliative care (PC), opioids, emotional support counsellors, psychological support groups, and pastoral and spiritual support. So, it increases the life expectancy of terminally ill patients, but patients suffering, perception of an incurable disease, and risk of death have elevated similarly. In addition, nurses show difficulties in managing the growing demand of terminally ill patients, which requires strengthening their care in the dying process, and working with the thematic death, especially with its association with feeling helpless and as though nothing else could be done for these patients (Miranda da Silva et al., 2012).

The need for PC is an essential treatment for controlling terminally ill patients suffering. It enhances the quality of life by helping patients and staff nurses manage terminal patients suffering physically, psychologically, and with severe symptoms (American Cancer Society, 2019).

Approaching PC at the end-of-life (EoL) can be ethically considered a global human right. National and international guidelines recommended the early integration of PC in treating patients with advanced cancer (Brennan, 2007; Singer & Bowman, 2002; Ferrell et al., 2017.; Jordan et al., 2018).

Numerous studies emphasized the positive effects of early incorporation of PC, which include enhanced symptom controlling and psychological well-being with less depression and anxiety; better quality of life for patients, relatives, and caregivers; less overtreatment and aggressive care at the end-of-life (Bakitas et al., 2015.; Vanbutsele et al., 2018; de Oliveira Valentino et al., 2020).

Hospital and hospices environment could enhance the following four types of interactions with terminally ill patients at EoL care: patient-to-family interaction, professional caregiver-to-patient/family interaction, patient-to-patient interaction, and facility-to-community interaction. Moreover, it reinforces staff in providing safe and high-quality care. Also, it would support patients in symptom management and improve their experience through unit/room layouts. Furthermore, it facilitates the closeness of the patient to the nursing station and visual access to patients. It maintains patients' privacy via rooms with designated spaces for family members, which leads to mood stabilizing and satisfaction (Zadeh et al., 2018).

A total of 43 reviews published between 2000 and 2019 examined the available evidence on the economic value of palliative and EoL care interventions across various settings. They showed that the most common evidence was cost-effectiveness related to home-based interventions, which reported significant savings to the healthcare system, including decreased total healthcare costs, resource use, and improvement in patient and caregiver outcomes. Meanwhile, the evidence of interventions delivered across other settings was generally inconsistent (Luta et al., 2021).

1.2.3 Oncology Nurses' Role and Obligation in End-of-Life Care

The nurse's role is crucial in understanding terminally ill patients' suffering and tailoring care plans to fulfil patient needs (Virdun, 2015). Furthermore, they must possess the knowledge, attitude, and skills that qualify them to provide a spiritual need cardinal in end-stage cancer. They affirm that spirituality-related actions, such as prayer and the provision of comprehensive care, impart meaning to the work of palliative care professionals since they involve the end-of-life process of

individuals and seek to humanize death, i.e., provide a dignified death (Arrieira et al., 2017).

Besides that, communication between oncology nurses and terminally ill patients and their families through open dialogue is vital to respect their will and avoid significant suffering (Vasques et al., 2016).

1.3 Description of the Study Context

1.3.1 General information about the Kingdom of Bahrain

The Kingdom of Bahrain is an archipelago of 33 islands in the Arabian Gulf in the middle of the Kingdom of Saudi Arabia and Qatar. Its total area presents 780 km². Manama is Bahrain's capital and largest city (Bahrain Authority for Culture and Antiquities, 2022).

According to 2021 statistics, the total population in the Kingdom of Bahrain is 1,504,365. Of it, 719,333 (47.8%) are Bahrainis, and 785,032 (52.2%) are non-Bahrainis. Bahrain is distinguished by four governorates, the Capital, Muharraq, Northern and Southern. Arabic is the official mother language, while English is also one of the common languages used in various sectors. Islam is the legitimate religion of the Kingdom of Bahrain and is accepted by the enormous majority. Places of followers of different religions are also available within the Kingdom (Information & eGovernment Authority, 2022).

1.3.2 Health Care Services in the Kingdom of Bahrain

Over the years, the Kingdom of Bahrain has reinforced its people with advanced healthcare solutions and programs. Bahrain has a comprehensive health care system

dating back to 1960, with all its citizens being provided free health care by the government and subsidised to expatriates to a certain extent. Also, the top priority for its government is ensuring a healthy nation, which met the 1990s objective ambitious "Healthcare for All." Today, it continues offering free and subsidized healthcare services to citizens and residents alike. Also, The Supreme Council of Health is responsible for setting strategies and national direction. At the same time, the National Health Regulatory Authority (NHRA) provides regulation, and the Ministry of Health acts as the sector's primary manager and operator (eGovernment Portal, 2022).

The Kingdom of Bahrain has been classified first in the Arab region as the healthiest country, with a mean life expectancy of 77.7 years (78.9 females and males 76.9) and 36th worldwide, among 169 countries around the world (Bloomberg, 2019).

In Bahrain, registered nurses working in oncology departments with different educational backgrounds, e.g., diplomas, bachelor, and master's degrees in nursing science. Their job designations are specialist nurse, general nursing specialist, and special nursing specialist. All nurses are licensed and eligible by the National Health Regulatory Authority (NHRA) and Civil Service Bureau to provide holistic nursing care in the scope of new evidence-based practice, practising leadership skills, and conducting research. Unfortunately, oncology nurses have no special designation that clarifies their scope of practice. There is also severe research insufficiency in nursing practice or experience in the oncology department at SMC.

1.3.3 Cancer Statistics in Bahrain

The average annual gross cancer prevalence and incidence rate for Bahraini males are 86.3/100,000, and for Bahraini females is 97.5/100,000. The mean age-specific

incidence rate of cancer is 136.4 and 135.8 per 100,000 Bahraini males and females, respectively, which is higher than in GCC states (Pedapenki & Madan, 2022).

The total number of new cancer cases in Kingdom of Bahrain is 1215 and the number of deaths caused by cancer in the general population of Bahrain 2020 by type was published by Statista Research Department, Sep 23, 2020, and declared that: "Based on the statistical report (2020) lung cancer caused 84 deaths in Bahrain, followed by breast cancer with 66 deaths". Moreover, the number of deaths caused by cancer among women in Bahrain is 293 compared to 310 among men (See Appendix 1) (Global Cancer Observatory, 2021).

1.3.4 Oncology Care in Bahrain

Cancer treatment has been accessible in the multi-specialty tertiary care hospital at Salmaniya Medical Complex (SMC) since 1997, which includes a radiotherapy unit. Afterwards, a chemotherapy unit and hemato-oncology services were added in 1999. After 2000, more Bahraini physicians trained abroad in oncological subspecialties, including medical, radiation, and surgical oncology, and started treating cancer patients requiring multidisciplinary care. In early 2019, a new centre was established in the kingdom of Bahrain – Bahrain Oncology Center (BOC) on King Hammad university hospital (KHUH) premises with advanced equipment, including the latest generation Linear accelerators, Brachytherapy, computed scans, and other Radio-nuclear pharmaceuticals. Moreover, the facility also offers bone marrow/stem cell transplantation. Bahraini citizens are treated free of charge, but non-Bahraini citizens are treated on payment to a certain extent (Pedapenki & Madan, 2022).

1.3.4.1 Palliative Care Track

Palliative and best supportive care are available at Salmaniya medical complex and BOC with multidisciplinary palliative care teams consisting of physicians, counsellors, dietitians, psychiatrists, pain management, and social support teams. Furthermore, Regular palliative care clinics provide supportive care and pain management. Unfortunately, no hospice care center is available in Bahrain (Pedapenki & Madan, 2022).

1.3.4.2 Oncology Nurse Services and Practice in the Kingdom of Bahrain

Governmental Hospital (GH) - Salmaniya Medical Complex (SMC), under the umbrella of the Supreme Council of Health, attempts to continuously meet the Secondary and Tertiary Health Care needs of the citizens and residents of Bahrain most effectively and efficiently with the highest level of quality within its existing resources. In addition, SMC functions as a teaching and research centre for healthcare professionals (Ministry of Health, 2022). Also, it is responsible for recruiting the nursing workforce to overcome hospital needs. The latest statistics in 2020 from the human resource at MoH about the nursing workforce showed 3,914 staff nurses (See Appendix 2). Female nurses are predominant, with a total number of 3,342, and male staff nurses, 572, with no precise number of the nursing workforce at SMC (See appendix 2) (Ministry of Health, 2020).

1.4 Statement of the Research Problem

Previous research studies explored the experience and perspectives of dying patients with cancer (Bloomer et al., 2017). In contrast, the experiences of nursing professionals who care for terminally ill patients were less examined worldwide.

Most of the published studies on healthcare professionals' experiences of palliative care have focused on the emotional wellbeing of specialist care team members (Tay & Hegney, 2012). Little data in the literature concerning emotions accompanying nurses while working with a dying patient is available. Additionally, only a few articles discuss strategies for coping with the emotions associated with death and dying patients (Kostka et al., 2021). Nurses' grief has not been sufficiently investigated in practice settings, it has been a well-recognized threat to health and work performance (Khalaf et al., 2017).

In the Kingdom of Bahrain, there are some studies related to cancer; meanwhile, there are no studies that reflect the experiences of oncology nurses with terminally ill patients. Therefore, this study explored the experiences of oncology nurses in providing care to terminally ill patients in context and the factors that affect the oncology nurses' experiences while caring for terminally ill patients.

1.5 Aim of the Study

The aim of the study was to explore to explore the experience of oncology staff nurses in providing care for terminally ill patients in the Salmaniya medical complex in Bahrain.

1.6 Research Questions

- What is the experience of oncology staff nurses in providing care for terminally ill patients?
- How does the experience of oncology nurses in providing care to terminally ill patients impact the quality of care provided to patients?

1.7 Research Objectives

The objectives of the study are:

- Describe the experience of oncology staff nurses' in providing care at the end of life of terminally ill patients.
- Explore factors that affect the oncology nurses' experience while caring for a terminally ill patient.

1.8 Significance of the Study

Assisting terminally ill patients and their families is a complex task, even for an experienced nurse, who sometimes may bear the difficulty of assisting dying patients and families. Many nurse professionals have bad experiences, particularly in the emotional and psychological aspects (Vegunta et al., 2016).

It was found that oncologist nurses' feelings, emotions, grief reactions, and coping mechanisms following their patients' death are burdened with overcoming their grief (Khalaf et al., 2017). Ay & ÖZ (2018) found a significant variation factor affected by working with dying patients: marital status, having a child, years of experience, and bereavement experience, which affects nurses negatively to face the concept of death concurrently; this is reflected in their attitude.

Coping with death and dying in nursing care and some cultural issues as the main factors that influence their psychological well-being, which in turn may have contributed to a reduced quality of care for patients (Al Zoubi et al., 2018). Moreover, de Brasi et al. (2020) indicated that oncology-hematological nurses frequently experience moral distress due to neglecting moral distress issues in most palliative education programs. This led to poor communication or a lack of

communication between nurse professionals, patients, and their relatives, and the inability to satisfy the patients' last requests. However, in oncology nurses' behaviour while providing palliative care, the burnout level of nurses working in palliative care is lower than that of health professionals working in other settings (Ricci-Allegra, 2018). On the contrary, fatigue is also prevalent among charge nurses, with high levels of burnout and secondary traumatic stress (Al-Majid et al., 2018).

Job descriptions for oncology and palliative care nurses are still in progress in Civil Service Bureau and NAHRA. However, there is a deficiency of research on oncology nurses' experience and practices in Bahrain. Also, an education program for palliative care has not yet been initiated.

1.9 Chapter Summary

This chapter introduced the background of the study and its context from the perspectives of oncology healthcare services in the Kingdom of Bahrain and Salmaniya Medical Complex and the current nursing practice and experience with terminally ill patients. In addition, it has presented the aim, objectives, research questions, statement of the problem, and significance of the study.

Chapter II

Literature Review

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

In this chapter, the researcher reports a review of studies in the discipline of oncology to explore nurses' experiences while providing care for terminally ill patients in the oncology setting. It also analytically and logically examines the existing literature and provides an extended broad pathway for discussion that help support and shape this thesis, sincerely the choice of study method and methodology.

Following UoB guidelines, the literature review process is carried out; the first section (2.2) provides a general overview of the literature review. The second section serves as an executive overview of cancer (2.3), the third section (2.4) states the features and suffering of a terminally ill patient, and the fourth section (2.5) illustrates the benefits of Early Palliative Care in EoL Care. The following section demonstrates terminally ill patients' advanced nursing roles and responsibilities. The last section (2.6) describes the nurses' experience with terminally ill patients.

2.2 Overview of Literature Review

The literature review is a written document that develops the case to establish a thesis. This case is based on a comprehensive understanding of the current knowledge of the topic. A literature review synthesizes current knowledge about the research question. In addition, this synthesis is the foundation that, with logical

argumentation, allows the researcher to build a convincing thesis case (Machi & McEvoy, 2021).

For this research study, the researcher adopted an integrative review method to review current knowledge about a nurse's experience with terminally ill patients to identify, analyze, and synthesize the results of independent studies on the same subject.

"An integrative review summarises the past empirical or theoretical literature to present a broader understanding of a particular phenomenon or healthcare problem (Rodgers & Knafl, 1993). Concept development in nursing: Foundations, techniques, and applications. Thus, have the potential to build scientific, informing research for practice, and policy initiatives, so this method enables for the inclusion of diverse methodologies (i.e., experimental and non-experimental research)" (Whittemore & Knafl, 2005).

An integrative review should be performed when using diverse data sources to develop a comprehensive understanding of the topic of interest by introducing the state of the science and contributing to theory development (da Silva et al., 2020).

The first stage of the integrative review from Whittemore and Knafl's (2005) point of view is to identify the problem, set objectives, and search questions considering concepts, populations, and types of studies. Accordingly, the researcher sets the aim for this study to explore the experience of oncology nurses while providing care for terminally ill patients in various geographical areas and settings and to explore their practice, knowledge, skills, and challenges they face while providing nursing and palliative care.

The literature review was carried out based on search questions that the researcher believed were essential to enrich the research discussion and help design the research methodology.

The search questions are:

- What are the factors affecting oncology nurse care for terminally ill patients?
- What challenges the oncology nurses face while providing care to terminally ill patients?
- What are the characteristics of oncology nurses working with terminally ill patients?
- What characteristics of terminally ill patients may affect the oncology nurses' experience?
- Does the oncology staff nurse own special communication skills with the medical team, patients, and their families?
- What is the experience of terminally ill patients and their families?

A literature review was conducted through a basic search strategy aligned with the second stage of Whittemore and Knafl's (2005) integrative review to organize the structure of key terms used to search a database. It also links the key concepts of the search questions to regain accurate results.

The databases, e.g., CINAHL, PubMed, Medline, and google scholar, were operated during this research process. Besides that, the search terms, keywords, alternative keywords, or phrases for the concepts are done with the help of a thesaurus to identify synonyms. Keywords for search include oncologist nurse, experience, Palliative care, emotion, compassionated communication, cancer, oncology, education, barriers, empathy, emotional distress, mental distress,

terminally ill, and patient. Truncated and wildcard searches are used to find variations of the search term in the form of singular and plural words and variant endings, e.g., "palliative*." Moreover, Boolean operators are also used to combine the search terms or results (AND, NOT, OR).

Inclusion and exclusion criteria of the integrative review were handled according to Whitemore and Knafl (2005) stages three and four of data evaluation and analysis. So, the researcher used data published from 1999 to 2022, considering qualitative approaches origin back to the early twentieth century within the health sector and nursing field.

In the past ten years, however, nurse scientists have begun to recognize that many phenomena of interest defy measurement by the traditional quantitative style and require more in-depth explanation and exploration (Speziale, 2011). This led to an increase in qualitative designs, defined as "widely acknowledged questions about individual experiences and certainties studied through continuous contact with persons in their natural environments and producing powerful, descriptive data that help us understand those persons' experiences" (Boyd, 2001).

This review's inclusion and exclusion criteria were employed to retrieve papers compatible with search questions and of sufficient quality.

The inclusion criteria for this research extend to include several points believed to pinpoint the critical aspect of research and answer research questions. Thus, primary and secondary studies in English, articles, and full theses from different nations, countries, and environments. They also search for quantitative, qualitative, and mixed-method studies about nurses' practice, skills, attitudes, knowledge, and experience with terminally ill patients. The search strategy

produced more than 566 articles and theses, but only 230 studies were included in this research for literature.

Regarding exclusion, the criteria for this research are studies with non-English language, protocols, and guidelines, as well as studies that cannot be generalized in a different setting.

Choosing an integrative review for this study was assumed to understand the density of the issues related to the oncology nurses' experience while delivering care for terminally ill patients with the diversity of participants involved in different contexts (inpatient and outpatient units). The integrative review was an effective method for a novice researcher to have a broad picture of the existing studies in the field of end-of-life care and identify the knowledge gaps.

2.3 Overview of Cancer

Cancer is a serious concern as a leading cause of death worldwide, which is manifested by abnormal and uncontrolled growth of cells that tend to proliferate and, in some cases, metastasis (Davis et al., 2017).

Hurteau (2019) declared that cancer is one of the top contributors to morbidity and mortality worldwide. In addition, it is a leading cause of death worldwide, accounting for nearly 10 million deaths in 2020 (Ferlay et al., 2020). Moreover, the Eastern Mediterranean Region (EMR) and the Gulf States countries show a frightening rise in the number of cancer patients, Long-term projections show that, by 2030 there would be a 1.8 fold increase in cancer incidence (Arafa et al., 2020).

The average annual gross cancer prevalence and incidence rate for Bahraini males are 86.3/100,000, and for Bahraini females is 97.5/100,000 (according to 2020 statistics). The mean age-specific incidence rate of cancer is 136.4 and 135.8 per

100,000 Bahraini males and females, respectively, which is higher than in GCC states (Pedapenki & Madan, 2022).

When the tumor cell morphology is changed or transferred to another body part, it can cause a real risk and complications. Also, it can be distinguished by bone metastasis pain, hypercalcemia, and venous thromboembolism (Tsuzuki et al., 2016).

When cancer cannot be cured or treated, referred to as terminal or end-stage cancer, any cancer can become terminal cancer, and terminal cancer does not respond to treatment (Holland, 2018).

Moreover, in all its phases, suffering is a common experience in human life. However, it looms particularly large at the end of life for patients dying from a lethal illness like cancer during the days, weeks, or months that follow when every treatment except palliative care has been stopped. Though occasionally, it is one symptom that causes severe, even extreme suffering (Hartogh, 2017).

2.4 Terminally Ill Patient Features and Suffering

People with advanced cancer confront various symptoms during their illness trajectory, which can fluctuate in intensity. Terminally ill individuals with cancer can experience severe pain, fatigue, nausea, vomiting, dyspnea, depression, and lethargy (Verkissen et al., 2019). Furthermore, they can encounter fear and anxiety if their physical needs are not met (Bovero et al., 2016). These terminally ill patients experience pain and suffer a lower quality of life, creating challenges for patients, families, and the healthcare system (Wang et al., 2018; Given et al., 2012).

Patients in their terminal phase face death, where death is likely to occur within hours to days or occasionally weeks. Also, they identified that they wish not to be overburdened with unnecessary interventions or perceived as a burden to others. So, this significant issue highlights that most terminally ill patients have correlated perceptions of loss of dignity, suffering, and a bad death (Clark, 2017).

2.4.1 Physical suffering and needs

The physical decline of persons with late-stage cancer consequently causes a loss of physical function (Iskandar et al., 2021). It is routinely acknowledged that persons with cancer experience physical suffering during their illness (Chan et al., 2018; Ellis et al., 2015).

Madsen et al. (2019) stated that physical symptoms, including pain and weakened physical strength, affect a patient's ability to move freely, increasing dependability on others and an inability to participate in society actively. Both patients and healthcare providers pointed out that physical activity during a hospital stay should be well-balanced with physical and mental rest. Koenders et al. (2018) conducted a study to understand patient and staff nurse perceptions of patient physical activity during hospital stays. Both patients and healthcare providers pointed out that physical activity during a hospital stay should be well-balanced with physical and mental rest.

Moreover, pain can cause suffering when it is uncontrolled or persists. Uncontrolled pain can lead to other physical impacts and significant disruption in quality of life (QoL). Uncontrolled pain has deleterious effects on one's outlook on life, often creating a sense of hopelessness (Liu et al., 2018). Chronic pain not only affects QoL but may predispose one to further complications psychologically and physically (Chapman & Gavrinn, 1999; Duenas et al., 2016; Fine, 2011).

Fatigue is one of the most severe and irritating symptoms cancer patients experience (Bower, 2014). De Raaf et al. (2012) described cancer patients' fatigue as a chronic, distressing, unpleasant emotional and cognitive exhaustion that causes tiredness throughout the day, negatively impacting daily activities. Many cancer survivors do not recover from fatigue after cancer treatment, and fatigue can persist for many years.

People in the advanced stages of illness, especially in the last few weeks of life, often lose their appetite; this may be because of other symptoms such as pain, sickness, or breathlessness. Moreover, the body gradually begins to shut down and cannot digest food; even small amounts of food might make the patient feel uncomfortably full or sick or find that eating creates stomach pain or diarrhea (Cancer Research UK, 2020).

Nausea and vomiting are usual and distressing symptoms complex in patients with far-advanced cancer, affecting up to 60% of individuals at some stage of their illness (Glare et al., 2008). Physical and psychological factors contributing to nausea and vomiting in terminal illness include medicines, e.g., opioids, non-steroidal anti-inflammatory drugs (NSAIDs), chemotherapy, and metabolic causes, e.g., hypercalcemia and kidney failure. Additional symptoms may include gastric stasis, constipation, inflammation, ulcers in the stomach, ascites, hepatomegaly, infection, bowel obstruction, brain metastases, and stress and anxiety (Marie Curie, 2021).

Breathlessness may become intolerable, especially with terminally ill patients afflicted by respiratory and cardiac complications. Cancer-related disorders present as deep vein thrombosis and pulmonary embolism, which lead to an acute

event or both because of a final stage of a chronic process. Breathlessness is associated with acute respiratory failure (Pisani et al., 2018).

2.4.2 Psychological Suffering and Needs

Terminally ill patients handle different challenges and repeatedly experience emotional and factual distress. Also, suffering at the end of life involves a complex and subjective experience in which understanding physical, psychological, social, and spiritual needs is crucial to inform meaningful and effective care (Krikorian et al., 2012; Bandeali et al., 2019). Psychologically, they may feel excluded from social life, mainly when others focus on their illness and the treatment (Madsen et al., 2019; van Roij et al., 2019). Sulmasy (2002) indicated that incorporating spirituality into psychological care is consistent with the biopsychosocial-spiritual model from which psychologists and nurses recognize their patients' problems as multifaceted. Therefore, addressing the patient's unique life experiences, values, and beliefs maintains personal dignity (Chochinov et al., 2002).

Spirituality has been identified as a significant dimension of quality of life and psychological well-being for patients at the end of life (Rego et al., 2018). Furthermore, Patients struggling spiritually (e.g., feeling abandoned by God) and seeking spiritually (e.g., the meaning of life) have worse overall psychological well-being and quality of life. A spiritual concern negatively affecting psychological well-being is doubting one's belief in God (Pearce & Denton, 2011; Winkelman et al., 2011).

Advanced cancer patients have a variety of feelings, such as hopelessness, depression, anxiety, and fear of death. Furthermore, significant concerns like these go unnoticed and unaddressed (Priyanka et al., 2018).

Dauman & Erlandsson (2012) described four areas of suffering: feeling mistreated, fighting for health care needs, including pain medications, and feeling powerless and objectified. Feeling mistreated stemmed from not being listened to, when symptoms were ignored, when no time was provided for questions, or when the patient felt he or she was not taken seriously. Other patients felt powerless when healthcare professionals did not encourage them to be part of their care. Additionally, when patients felt secondary to their disease and their experiences were not considered, they felt objectified.

2.5 Benefits of Early Palliative Care in End-of-Life Care

The early integration of appropriate palliative care into standard care is essential to provide terminal cancer patients with good quality care at the end of life (Fitzmaurice et al., 2018).

Previous studies have investigated the benefit of palliative care on cancer patients and definite that palliative care enhances patient and caregiver outcomes and is associated with fewer medical interventions near the end of life (Temel et al., 2010); Kavalieratos et al., 2016). Chang et al. (2022) emphasized this point through their study, which aimed to measure the advantages of palliative care for cancer patients. However, the characteristics of receiving palliative care and the utilization patterns among cancer patients have not been explored using a large-scale representative population-based sample to include 5,068 cancer patients and 25,121 patients (50.1%) who had palliative care during the study period. So, they conclude that Clinical evidence demonstrates the benefits of palliative care as it is associated with efficient end-of-life healthcare utilization. Also, patients with higher household incomes were more likely to receive palliative care than those in lower-income groups. In addition, during hospitalization, receiving palliative

care was associated with an 11.2% lower length of stay (LOS) and 28.4% lower discounted total charges than the non-receiving group.

Moreover, identifying patients with limited life expectancies and urgent palliative care needs can be challenging. So, Advanced care planning for patients' wishes and goals often takes place too late; consequently, many patients with advanced cancer and a limited life expectancy are admitted to an emergency department (ED) (Barbera et al., 2010; Qureshi et al., 2018).

Verhoef et al. (2020) conducted an observational cohort study to provide insight into the visit of advanced cancer patients to the emergency department (ED) at their end of life. Their study sample includes four hundred twenty patients with a median age of 63 years, 54.6% on systemic cytotoxic treatments, and 10.5% received home care ≥ 1 per day.

In 34.0% and 51.9% of patients and family-initiated ED visits occurred during out-of-office hours. Furthermore, 33.8% of life-sustaining treatments were discussed before patients visited the ED, and limitations in 70.7% after the ED visit. Moreover, the median residence at the ED was 3:29 h (range 00:12–18:01 h), and 319 (76.0%) were admitted to the hospital. The median survival was 18 days (IQ range 7–41). One hundred four (24.8%) died within seven days after the ED visit, of which 71.2% were in the hospital. Lastly, they conclude that ED visits of terminal cancer patients often lead to hospitalization and in-hospital deaths. Moreover, urgent palliative care intervention and awareness among ED staff may improve the end-of-life trajectory of these patients.

Yadav et al. (2020) performed a systematic review between 2008 and 2018 to weigh the differences in the healthcare cost of palliative care for cancer patients in several delivery models of palliative care currently available: hospital-based,

outpatient-based, home-based, nursing home-based, and hospice-based. Results revealed that the initial search identified 748 articles, of which 16 met the inclusion criteria. Eight studies (50%) were inpatient based, four (25%) were merged outpatient/inpatient, two (12.5%) reported only on home palliative services, and two (12.5%) were in several settings. The majority of studies showed that palliative care reduced the cost of health care by \$1285–\$20,719 for inpatient palliative care, \$1000–\$5198 for outpatient and inpatient combined, \$4258 for home-based, and \$117–\$400 per day for home/hospice, combined outpatient/inpatient palliative care. So, early integration of palliative care after a cancer diagnosis was associated with lower costs for cancer patients, and remarkable differences exist in cost saving across different palliative care models (Yadav et al., 2020).

In addition, an integrative literature review synthesized and summarized research evidence from the fields of medicine, environmental psychology, nursing, palliative care, architecture, interior design, and evidence-based design conducted by Zadeh et al. (2018). Zadeh et al. 2018, aimed to organize and analyze the evidence related to environmental design factors that improve the quality of life and total well-being of people involved in EOL care and clarify directions for future research. So, a critical analysis of the results from 225 educational documents revealed several environmental factors that should be considered to improve quality of life and minimize suffering in EoL settings. The five factors that appeared most frequently in the literature search and that recommend being targeted by environmental design interventions are 1) social interaction, 2) positive distractions, 3) privacy and control, 4) personalization and a home-like environment, and 5) ambient environment. Other factors discussed include

spirituality, optimization of space and layouts, amenities, and cleanliness (Zadeh et al., 2018).

2.6 Advance Practice Nurses' Role and Responsibilities with Terminally Ill Patients

Nursing practice is rapidly evolving, and patient pathways are becoming more efficient and cost-effective (Norlyk et al., 2017). which means that nurses not only have to take care of the needs of patients and their families; they also face multiple demands from medical teams and hospital management in their daily work setting. Angheluță et al. (2020) stated that when experienced nursing staff adjusts the EOL's care plan and the multiple strategies employed to tailor the care plan to patients evolving needs, it results in immediate care changes. Also, it sheds light on the implicit clinical processes that inform decision-making care adjustments and implementation-related strategies, which are essential to improve the quality of end-of-life care.

Therefore, a deep understanding of suffering and its complex consequences is vital for health professionals such as nurses, doctors, and close relatives of the patient to enable them to recognize and address the suffering and assist in healing (Hartogh, 2017).

Zheng & Owens (2015) believed that if nurses attempt to meet the holistic demands of terminally ill patients, they should respect their self-preferences. They should show appropriate interactions and be sensitive to their needs (Lee & Seomun, 2016; Sayers & de Vries, 2008).

Effective cancer management is accomplished with a multidisciplinary team, and well-skilled nurses play a central role in a functioning team (Uwayezu & Fitch,

2020). The nurse has a crucial role during the cancer treatment decision-making process; oncology nurses experience heavy workloads and deliver more complex and advanced care to more seriously ill patients. Several studies affirmed that nurses spend more time with patients than other healthcare professionals, and oncology patients spend a significant period in oncology hospitals (McCarter & Szubski, 2015; Lemonde & Payman, 2015; Kieft et al., 2014).

The palliative team offers relief, support, and comfort to patients. Meanwhile, nurses struggle to manage the growing demand for patients with terminal illnesses, which requires strengthening their demonstration of caring in the dying process. Also, learning to work with thematic death is mainly associated with their helplessness, and they thought nothing else could be done for these patients (Miranda da Silva., 2012).

Oncology nursing care is a highly specialized subset of practice that requires higher training and education following essential preparation. When nurses grasp the opportunity to learn about cancer care, their specialized knowledge and skill can influence the quality of care for patients and families (Challinor & Williams, 2016). The American Association of Colleges of Nursing (AACN), the national voice for academic nursing, believes that education has a significant influence on the knowledge, skills, and competencies of the clinical nurse, as it does for all healthcare providers.

The hallmark of nursing is a holistic approach (Choe & Park, 2015), so they must own unique skills that enable them to care for terminally ill patients. Moreover, the treatment of the biological dimension, e.g., pain, nausea, and constipation; the psychological dimensions include management of anxiety, depression, and

agitation; caring for the patient's loved ones (the social dimension); and identifying spiritual distress (the spiritual dimension) (Giezendanner et al., 2017).

The fast evolutions in healthcare and the professionalization of nursing have increased the implementation of advanced practice nurse (APN) roles internationally and the number of advanced practice cancer nurses in the coming years (Decadt et al., 2020).

Evidence from workforce analyses demonstrates that oncology nurse practitioners (ONPs) provide significant care to patients with various malignancies in various settings (Bruinooge et al., 2018; Moote et al., 2011; Ruegg, 2013). There are varying estimates of nurse practitioners providing cancer care, ranging from 3,600 to 4,800, but the number has increased in the past decade (Bruinooge et al., 2018; Coombs et al., 2019).

APNs have completed a master's degree and additional education and training in a specific clinical domain, such as oncology (Decadt et al., 2020). The core competencies of APNs are clinical practice, expert coaching and guidance; consultation; collaboration; improvement of quality care and innovation; leadership; research, and ethical decision-making (Gibbons, 2014).

2.6.1 Improving the quality of care and innovating care (direct patient care competency)

Driven by clinical practice, evidence, and new evolutions in cancer care, APNs observe problems, risks, unmet needs, and areas for quality improvement. Besides, they initiate, develop, and implement quality improvement projects that innovate care and further professionalize the nursing profession. APNs also put research evidence into practice and typically bridge the gap between theory and practice. In addition, participating in nursing and multi-professional networks contribute to

policy and quality of care both within and outside the care organization. So, it requires change management skills to encounter direct patient care demands (Coolbrandt et al., 2018).

2.6.1.1 Pain management

Nurses and healthcare providers have a moral obligation to respond to patient needs. They are ethically eligible to take action against the disparities associated with access to pain management (American Nurse Association, 2016).

On the one hand, Siler & Ferrell (2019) conducted a study to figure out the relationship between pain, spirituality, and suffering of cancer patients. They declared that: "oncology nurses considered the front line of pain management for patients through recognizing existential distress and suffering and reacting to suffering."

Lowey (2020) performed a study describing current evidence-based strategies to manage severe pain in patients with terminal illnesses. The result revealed that nurses in the care setting must use pain assessment tools consistently and document the patient's pain levels and responses to the pain management intervention in the medical record.

2.6.1.2 Fatigue management

The supportive educational nursing care program can effectively alleviate fatigue and improve the quality of life in patients with terminal illnesses through individualized supportive nursing care. Also, it is recommended to give positive emotional support and improve patients' fatigue and quality of life through continuous assessment, counselling, and patient education (Wang et al., 2016).

2.6.1.3 Loss of appetite management

A collaborative multidisciplinary team is needed to ensure a comprehensive approach to managing dysphagia, reflecting the risks and values of eating and drinking for each individual to enable optimal quality of life (Royal College of Physicians, 2014; British Geriatrics Society, 2012).

For patients in the terminal illness stage, the goal of nutrition therapy is unlikely to be focused on maintaining energy intake, weight gain, or reversal of malnutrition during feelings of hunger and thirst. Nutritional needs should be tailored to their symptomatic needs and to support comfort and quality of life (Homan, 2017).

2.6.1.4 Nausea and vomiting management

Nurses should be knowledgeable enough to participate in antiemetic administration, assessment, patient education, and self-care. Therefore, nursing contributes to improving patients' quality of life to minimize the occurrence of chemotherapy-induced nausea and vomiting (CINV). Nurses need to expand their roles to improve their knowledge, assessment, and quality of nursing intervention (Ashikaga, 2019).

Nurses reported their awareness about developing CINV, but eventually, the CINV was often controlled poorly for their patient cohort. Antiemetic drugs were preferred for patient care by physicians; however, nurses recognized the need for more efficient communication among physicians, nurses, and patients, as well as the use of a standardized assessment tool, to increase the awareness and management of CINV (Blanco-Montenegro et al., 2018).

2.6.1.5 Dyspnea

When a patient's self-reporting ability is lost, the oncologist care nurse must rely on signs of a patient's respiratory distress. When the patient dies, there is only one chance to optimize the assessment and treatment of symptoms. The critical care nurse ensures that distress is assessed and treated expeditiously (Campbell, 2018).

Proper education of medical practitioners on appropriate inhaler uses and the correct use of dry-powder inhalers and metered-dose inhalers is crucial and suggested to ensure adequate response to inhalers and symptom relief. Therefore, the proper knowledge can be passed on to patients to increase the benefit of the treatment and avoid suboptimal drug delivery and, as a result, subpar symptom control (Senderovich & Yendamuri, 2019).

2.6.2 Expert coaching and guidance competency

APNs offer expert coaching and guidance by utilizing evidence-based knowledge and advanced clinical perspective for cancer patients and their families during illness trajectories, transitions, and complex clinical issues (e.g., education, self-management support, counselling, care planning, Etc.). Moreover, they navigate and support cancer patients to prevent, detect, and deal with the consequences of their illness and treatment (Oncology Nursing Society, 2013). In addition, their role can offer survivorship care during the transition between treatment and follow-up, screen for additional needs and refer to adequate healthcare professionals and offers to teach and coach oncology nurses involved in patient education and self-management support during cancer treatment. Furthermore, they can assess nurses' educational needs for professional development and develop tools to support this care (Goemaes et al., 2019).

2.6.2.1 Psychological suffering management

Oncologist nurses provide comprehensive and therapeutic expertise while assessing the cost-effectiveness of resources, considering dying patients' physical comfort and wish fulfilment. Nurses should take a positive attitude toward the dying patient, and the patient's condition should be given great attention. Moreover, they should take active treatment to relieve patients' anxiety and insecurity. Also, nurses should support dying patients' relatives. (George, 2016.; Wang & Li, 2018.; Wang et al., 2018.; Kleinpell et al., 2019).

Moreover, for terminally ill patients, it was possible to affirm that spirituality-related actions, such as prayer and the provision of care, impart meaning to the work of palliative care nurses since they involve the end-of-life process of individuals and seek to humanize death, i.e., provide a dignified death (Arrieira et al., 2017).

Rohani et al. (2018) obtained a study about clinical empathy with cancer patients: a content analysis of oncology nurses' perception; they stated that clinical empathy presents in five categories, including co-presence (physical and emotional presence), metacognition (self-awareness of mental processes), perception (knowing about individual awareness), inherent (genetic) and didactic (instructive) nature. Clinical empathy can be considered an effective strategy to be taught through three strategies: co-presence, metacognition, and perception within the context of cancer care. Thus, clinical empathy should be considered one of the competency standards which can be taught to oncology nurses.

Providing emotional and psychosocial care is a significant task among nurses in palliative care; understanding the process of psychosocial care and emerging it with specialized mental health care in a team might enhance the quality of

psychosocial care in palliative care (Skilbeck et al., 2002.; Skilbeck & Payne, 2003; Fan et al.; 2017).

Long, 2011 emphasized that healthcare professionals must think about various aspects of care; for instance, decision-making regarding life-sustaining treatment, transplantation, or end-of-life care/rituals, are often culturally based on spiritual or religious implications.

Hurteau (2019) identified that oncology nurses are in a unique position regarding patient care. Frequently, nurses are the healthcare professionals devoting the most time to their patients. Nurses are continuously assessing patients' tolerance to treatment, monitoring side effects, and providing psychosocial support to patients in need.

Terminally ill cancer patients possess complex medical and psychosocial needs at the end of life (Vegunta et al., 2016). Caring for an EoL patient is a challenge that needs both advanced skills and professional attitudes regarding the provision of this care (Lai et al., 2018).

2.6.3 Collaboration

Effective communication and collaboration among healthcare professionals improve patient and clinical outcomes. Interprofessional collaboration is essential to improve the quality and effectiveness of care. APNs collaborate in a stimulating and constructive manner with individuals, teams, or groups (of both patients and clinicians). However, they may also collaborate at the organisational, national, and international levels. Their clinical competence and leadership skills are pivotal for establishing collaborative relationships.

2.6.3.1 Effective communication

Besides, nurses can support terminally ill patients through compassionate presence, listening, and providing communication that enables patient expression and eliminating sources of suffering such as physical pain (Beng et al., 2017). Through dialogue between the nurse and patient, the nurse can document and share information with other members of the health care team and include the chaplain for further assessment and intervention. The active participation of professionals from psychosocial and spiritual disciplines (e.g., chaplains, psychologists, and social workers) is of great importance in responding to suffering (Balboni et al., 2017).

Nurses often encounter families who suffer from the imminent loss of one of their members (Norouzadeh et al., 2019). The terminal illness stage requires the involvement of staff nurses with a family member of a terminally ill patient and the importance of communication between oncology nurses and terminally ill patients and their families.

Vasques et al. (2016) stated that an open dialogue with patients and families is important and necessary to respect their will and to avoid major suffering. Consistent education is necessary, especially from the obstacles experienced in the work environment, such as those relating to the terminally ill, which is recommended to be delivered through continuing education, humanizing, and qualifying the nursing care, as well as maintaining dignity and comfort for patients and their families.

2.6.4 Role of palliative care nursing

The evidence reinforces that nurses work in a variety of roles. The expert nursing role decreases the suffering and burdens of those facing death and the ability to offer support for the distinctive physical, social, psychological, and spiritual needs of the patients and their families (Singer et al., 2016; End of Life Nursing Education Consortium (ELNEC), 2017).

Therefore, palliative nursing is a branch of the nursing field that continues progressing as the science of nursing and palliative care progresses. The palliative care RN and APRN specialist has expert knowledge in palliative care, including the disease's pathophysiology, advanced patient and pain assessment, management, counselling, and communication skills for advanced care planning, in addition to advanced knowledge about caring for individuals with severe, life-threatening illnesses and those who are imminently dying (Bradley et al., 2001; American Nurses Association, 2017).

Johansen & Helgesen (2021) designed a qualitative study to explore the experiences related to the role of the resource nurse in palliative care in the setting of nursing homes in Norway. The result revealed that the resource nurse's most vital tool in encouraging high-quality palliative care might be supporting their colleagues as role models and sharing knowledge and experience. Resource nurses play an essential role in facilitating expression and cooperation in the palliative care team and may impact ethical awareness and proper dialogues about EoL issues.

Palliative home visits can offer consultation in a home-based setting. This includes some of the complexity, time-consuming care coordination, symptom management, and EoL care. Efficient models that utilize nurses, APRNs, RN, and

social workers, to manage the person's medical, medication, activities of daily living, social, and care coordination needs (Schroeder & Lorenz, 2018).

2.7 Staff nurses' Experience with Terminally Ill Patients

Oncology nurses are key clinicians whose opinions, attitudes, strategies, and competencies could determine the degree and success of patient participation in their cancer care (Pongthavornkamol et al., 2018). Also, they are healthcare professionals who are with the patients in both their good and bad moments, from diagnosis to treatment or until palliative and EoL care, and closely witness patients' disease journey (Güner et al., 2018). Moreover, as members of the healthcare team, nurses who spend much time with patients face significant challenges in caring for patients with diagnosed cancers (Kendall, 2006).

It is essential to recognize oncology nurses' experiences to understand and support their roles in patient care since specialized nurses are needed to meet the needs of patients and their families (Davis et al., 2017).

2.7.1 Oncology nurse Experiences during delivery of care to terminally ill patients delineated by different factors

Kgosana et al. (2019) conducted a qualitative phenomenological, descriptive, exploratory study to describe the experiences and practices of nurses caring for terminally ill patients in the Pietersburg Provincial Hospital; they state that caring for terminally ill cancer patients is physically, emotionally, and spiritually demanding. Furthermore, most oncology nurses blame themselves, feeling a sense of guilt for not doing enough to help the cancer patient to survive, and usually, they demonstrate avoidance behavior to cope with their discomfort about the death of the patients or the difficulty of caring for patients in severe pain.

Barbour (2016) formulated a self-study to explore what impact grief has on oncology nurses as she experienced feelings of grief after the loss of several patients she had come to know. She concluded that while sadness or grief was the most common emotion she experienced, she also expressed a wide range of other emotions throughout the data (e.g., fatigue, frustration, anger).

Kostka et al. (2021) a diagnostic survey method was used, via a questionnaire designed by the author of the study to include 160 staff nurses from a different department, involving the feelings of nurses elicited by the death of patients to evaluate and analyze the feelings and emotions which associate nurses during their work when they face the death of patients. They conclude that the most communal emotions accompanied by the patient's death were compassion, sadness, and helplessness. Among nurses with five years of work experience, the most expressed emotions while handling a dying patient were helplessness (62.5% of the respondents), compassion (54.17%), sadness (54.17%), and depression (41.67%). Nevertheless, in the group with more than 20 years of service, the prevailing emotions included compassion (68.83%), sadness (58.44%), and helplessness (44.19%). The research revealed that nurses with long service in work manage their emotions best.

Ogińska-Bulik and Michalska (2021) conducted a cross-sectional study in the hospice and the Non-Public Care and Treatment Center for the Chronically ill in the Świętokrzyskie province (Poland), with a total of 72 questionnaires. Analyzed data revealed that nurses working with terminally ill patients are exposed to negative consequences in the form of job burnout that arises from work-related stress and secondary traumatic stress (STS). Negative associations between resilience, job burnout, and secondary traumatic stress.; no significant correlations were observed between age and intensity of STS ($r = -.03$) and job

burnout ($r = -.01$). Similarly, no links were observed between the number of years of practice and the two variables: STS ($r = .02$) and job burnout ($r = .11$). The participants' educational level did not influence the intensity of STS. Moreover, The type of workplace influenced the level of STS and job burnout, with the hospital nurses revealing slightly greater severity of STS ($M = 44.28$, $SD = 0.77$) and higher mean job burnout scores ($M = 50.51$, $SD = 7.74$) than the hospice nurses (STS: $M = 37.55$, $SD = 9.29$, $t = 2.98$, $p < .05$; job burnout: $M = 42.55$, $SD = 8.00$, $t = 4.04$, $p < .001$). Lastly, nurses who adopted methods for resilience such as 1) emotional and psychological support leading to persistence and flexible adaptation to life demands, 2) an ability to take corrective actions in difficult situations, 3) and tolerance of negative emotions and failures were found to have a lower level of burn out while working with a terminally ill patient, while a positive correlation between STS and job burnout as nurses.

Caring for an EoL patient is a challenge that requires both advanced skills and appropriate attitudes regarding the provision of this care. So a cross-sectional study was conducted by Laporte et al. (2020), which aimed to determine nursing students' attitudes toward caring for terminally ill patients, self-perceived nursing skills, and the personal impact of instruction. Their study includes a total of 178 participants. The study revealed that after breaking up the total score to assess each item separately, the greatest positive attitudes were figured out in the listed items: item 17, 'As a patient nears death, the nonfamily caregiver should withdraw from his/her commitment with the patient' (mean: 4.6, SD : 0.6, median: 5); item 19, 'The dying patient should not be permitted to make decisions about his/her physical care' (mean: 4.6, SD : 0.7, median: 5); and item 21, 'It is valuable for the dying patient to verbalize his/her feelings' (mean: 4.6, SD : 0.6, median: 5).

Furthermore, the most negative attitudes were associated with item 3, 'being uncomfortable talking about imminent death with the dying patient (mean: 3.1, SD: 1.2, median: 3); item 7, 'The length of time required to give care to a dying person would frustrate me' (mean: 2.3, SD: 1.1, median: 2); and item 26, 'I would be distressed if I entered the room of a terminally ill person and found him/her crying' (mean: 3.1, SD: 1.2, median: 3). In conclusion, research finding suggests that caregivers who feel comfortable and competent with end-of-life care have a positive attitude toward providing such care (Laporte et al., 2020).

Palliative nurses in an academic hospital tend to inhibit their emotions and adopt a rational attitude in palliative care to avoid provoking emotional attachment when caring for cancer patients (Tay et al., 2012).

Salmond et al. (2017) described the experiences of direct care nurses with work-related compassion fatigue, and the perceived cumulative demands of experiencing and helping others through suffering have been considered to contribute to the potential of compassion fatigue (CF). CF may emerge as nurses continually connect with suffering patients and absorb their suffering or pain or when nurses caring for traumatized patients may re-experience their patient's traumatic events (McHolm, 2006). Mazza (1997) equates CF with secondary traumatic stress, wherein caregivers experiencing CF do not physically experience the traumatic events but experience the event emotionally while caring for the patient. Coetzee and Klopper (2010) definition of CF goes further than the experience of STS, described as it is the final result of a progressive and cumulative process that is caused by the prolonged permanent and intense contact with patients, the use of self, and the exposure to stress.

Moreover, nurses frequently considered their core task to be medical management, and both nurses and patients emphasized the physical care provided by the nurses; it suggests that a focus on the physical comfort of the patients could enhance the patients' psychological well-being (Chan et al., 2018).

Medland et al. (2004) described stressors specific to oncology as including administering complex treatments, communicating with patients and families about treatment options, treatment failure, and dealing with death, ethical issues, and decision-making. In addition, interdisciplinary conflicts and complicated discharges become the responsibility of the nurse to resolve.

2.7.2 Oncology nurses facing challenges and obstacles restricted end-of-life care for terminally ill patients and their families

Oncology nurses have more stressors than nurses in other units. They face challenges both within and outside the work environment that affect them negatively (Al Zoubi et al., 2020).

Nurses caring for terminally ill cancer patients experience challenges, despite aggressive efforts to reduce high death rates and extend the life of the patients (Frommelt, 2003). Press et al. (2009) viewed the effort of oncology nurses caring for terminally ill cancer patients as a complex issue, especially elderly patients. Because of their age, the elderly is predisposed to complications, which adds to the burden experienced by nurses, becoming more difficult for nurses to care for their patients. In comparison, the nurses experienced sadness as they witnessed the transformation in their patients' physiological and physical conditions. They felt it was unfair when their patients were young and had their lives cut short by illnesses (Akdeniz et al., 2021).

Dehghan-Nayeri et al. (2018) obtained a study to explore factors affecting missed nursing care in oncology units from the perspective of nurse managers. The result highlighted many factors affecting nurses' experience providing care for terminally ill patients, subsequently affecting the quality of their care. So, they declare that according to nurse managers', staff shortages, time constraints, and repetitive and time-consuming jobs can result in missed nursing care for hospitalized patients with cancer. Healthcare agencies also temporarily employ new graduates with no work experience in oncology units; due to the improbability of obtaining permanent employment and their temporary tenure, graduates lack organizational commitment and feel no obligation to fulfil their responsibilities. Also, nursing staff shortages affect the quality or quantity of healthcare and decrease nurses' motivation regarding comprehensive care provision or care based on scientific principles. It also leads to forgetfulness, work overload, stress during their shifts, exhaustion, task conflict, and turnover intention.

Cultural aspects affect oncologist nurses' experience as presented in some cultures, such as Chinese culture considers death a taboo in traditional that increases the difficulty of effective communication between nurses, patients, and families. Although nurses suffered emotional distress when caring for dying cancer patients, these experiences helped them to reflect on the meaning of death and life. They positively influenced their daily lives, attitudes, and behaviors toward caring for the dying (Zheng & Owens, 2015).

While End-of-life discussions are incredibly challenging for healthcare professionals in an increasingly diverse society, with the involvement of emotional and interpersonal issues (Searight & Gafford, 2005), Western cultures tend to emphasize more autonomy. In contrast, Asian cultures believe that communities and families, not individuals alone, are affected by life-threatening

illnesses and the associated medical judgments. Asians value beneficence in terminal illness by encouraging hope (Akdeniz et al., 2021).

Educational gaps remain one of the main barriers to implementing palliative care in patients with unmet needs; thus, nursing knowledge regarding palliative care is insufficient (Jaykumar et al., 2012). In addition, nurses could not potentially be utilized as an asset in identifying terminally cancer patients who should receive palliative care (Johnson et al., 2011).

2.7.3 Open, trust, and compassionate communication skills of an oncology nurse

Time pressures, closely tied to heavy workloads and understaffing, hinder patients from disclosing their concerns and expressing negative emotions to healthcare professionals (Finset et al., 2013). Time pressures also restrain nurses from supporting patients emotionally through effective communication (Zamanzadeh et al., 2014).

In oncology wards, the development of nurse-patient empathic communication is significant for patients because it relieves mental stress (Taleghani et al., 2017), reduces anxiety, gives pain control, and increases emotional compatibility and hope (Ono et al., 2012).

Inadequate communication often results in less adequate care, as many patients and families prefer healthcare professionals to be more forthcoming in initiating EoL discussions and assisting them in making suitable choices in the planning of care (Csikai, 2006; Parker et al., 2007).

Practical, harmonious, and patient-centered communication helps to overcome physical discomfort, allows emotional and spiritual distress, minimizes suffering,

and helps the patient and family members to go through the process of disconnecting from each other and disconnecting the sick individual from life (Marcassi et al., 2020).

2.8 Chapter Summary

In this chapter, the researcher followed a narrative review method to extract a possible theme that helped to design research objectives and questions. Four themes were identified because of the literature review process: overview of cancer, terminally ill patients' features and suffering, APNs' role and responsibilities with terminally ill patients, and nurses' experience with terminally ill patients. The data gained through the literature helped the researcher find the existing experience of nurses with terminally ill patients in the Arab Gulf region and globally, which helped to explore staff nurses' experience in Bahrain while providing care for the terminally ill patient at Salmaniya Medical Complex. The literature review outcomes helped the researcher determine the possible methodology for this research, which will be discussed in the next chapter.

Chapter III

Methods and Methodology

CHAPTER THREE: METHODS AND METHODOLOGY

3.1 Introduction

This chapter discusses the qualitative approach used for this research to explore the experience of oncology staff nurses while providing care for terminally ill patients in two settings, outpatient, and inpatient, at Salmaniya Medical Complex (SMC). Thus, sections (3.2 and 3.3) provided detailed information about the study design and setting.

Moreover, sections (3.5 and 3.6) interpret the sampling technique and sample size recruited in the research. The data collection process started after ethical approval was gained from the Scientific Research and Publication Committee at the UoB and SMC, Research & Research Ethics Committee for Government Hospital's explanation, is detailed in section (3.7). Furthermore, Section (3.8) interprets the data analysis process, and section (3.9) presents how data saturation is maintained throughout the data analysis. Moreover, sections (3.10 and 3.11) explain the study's rigor.

3.2 Study Design

A qualitative descriptive, interpretive exploratory design was used. Qualitative research concerns everyday human experiences in a natural environment (Maree & Pietersen, 2016).

Descriptive and interpretive are terms used interchangeably; designs focus on how participants make meaning of a situation or phenomenon. The researcher describes

collective experiences and seeks to discover or understand the participants' points of view (Merriam, 2009).

Because the researchers aimed to describe and explore the experiences and practices of oncology nurses caring for terminally ill cancer patients in the Kingdom of Bahrain at Salmaniya Medical Complex. The researcher interviewed nurses in oncology wards/units where terminally ill cancer patients were treated.

3.3 Study Setting

SMC is a governmental hospital in the Kingdom of Bahrain, which is meant to provide accessible medical services to all people, which includes 65 wards of different specialties, and a total of 1238 beds (see appendix 3). Moreover, the staff nurse workforce presents 2364 (see Appendix 4).

This study occurred at the Oncology units, including both inpatient and outpatient at SMC. Inpatient units include four wards with the scope of practice intended to treat adult male and female cancer patients, either newly diagnosed or terminally ill stage, but for a recent time, no active chemotherapy or treatment for new cancer cases. In contrast, terminal-stage cases were admitted for conservative measures, palliative care, and chemotherapy. Ward capacity includes fifteen to twenty-two beds for each ward with an admission mean rate of 30-40 patients monthly. The oncology clinic (outpatient setting), which also receives male and female adult patients with stable cancer disease and terminal stage end-stage, includes a multi-consultation room for outpatient follow-up with a consultant oncologist, doctor, dietitian, and counsellor. Also, the chemotherapy day care unit contains eight beds to receive terminally ill patients for palliative chemotherapy, adjuvant therapy,

antibodies therapy, and injection, with a monthly mean admission rate of 117 patients.

3.4 Ethical Consideration

Fleming & Zegwaard (2018) highlight some ethical dilemmas that an 'insider researcher' commonly encounters, including the power differential and ongoing relationships with participants. It is, however, significant to further consider the fundamentals of ethical research involving human participants.

Ethical considerations have a particular resonance in a qualitative study due to the in-depth nature of the study process. The concern of ethical matters becomes more salient when conducting face-to-face interviews with vulnerable participants. They may become stressed while expressing their feelings during the interview session (Arifin, 2018).

Urging and emphasizing the importance of ethical principles began with obtaining ethical approval from the Scientific Research and Publication Committee at the Collage of Health and Sport Sciences with referral code CHSS SRPC Recommendation No: 3/2021-22 dt. Oct 21, 2021(see Appendix 5). Moreover, a subsequent separate ethical approval was requested and gained from SMC Research & Research Ethics Committee for Government Hospitals, serial no: 12208112 (see Appendix 6). In addition, permission was taken from the nursing administration and the head nurse of the Oncology Department.

This chapter will discuss ethical considerations in three dimensions: informed consent, anonymity and confidentiality, and autonomy.

3.4.1 Informed Consent

The process of gaining consent consists of the following: consent should be given voluntarily, participants should understand what is being asked for, and involved persons must be competent participants to consent (Connelly, 2014). This refers to participating in a research study; participants need to be adequately informed about the research, comprehend the information, and have the power of freedom of choice to decide whether to participate or decline (Polit & Beck, 2014). Participant Information Sheets and Consent Forms are essential aspects of the organization and conduct of a study. The Participant Information Sheet gives potential participants the necessary understanding of the motivation and procedures of the study and sources of information to answer any further questions to allow them to provide informed consent (Cambridge, 2022; Barna, 2013).

Before starting the data collection phase, informed consent (see Appendix 7) and participant sheet (see Appendix 8) were disseminated in English to the Nurse Supervisors of inpatient and outpatient units. Participants were asked to complete the required documents within 24 to 48 hours before participation in the study to ensure the willingness of staff nurses' who meet the research requirements and to confirm and declare their agreement or disagreement to participate in the study. Then interview appointments were scheduled by units' supervisors immediately after their agreement. A further explanation was given about the aim of the study, the nature of the interview, and the content of the interview will be recorded via Integrated Circuit record (IC record). Participants were instructed to contact the primary researcher or supervisors for any doubt about their anticipation of the study.

3.4.2 Anonymity and Confidentiality

Participants' confidentiality was protected by not disclosing their names, identity, and workplace throughout data collection, data analysis, reporting of the study findings session, and dissemination of the findings. Moreover, each participant ensures anonymity using a study letter and number (see Chapter 4, Section 4.2).

In Bahrain, the Personal Data Protection Law No. (30) of 2018 was published in the Official Gazette on 19 September 2018 and came into force on 1 August 2019 (see Appendix 9).

The researcher stressed the privacy and confidentiality of the interview environment. Each interview was conducted separately and individually in a private and quiet room in the oncology unit, ensuring no outsiders' access. The researcher only has the right and authority to match the identity of the participants and voice recordings. The recorded file was saved in a locked locker at the university and explained to participants that only the research supervisor could reach it for academic and official use and would be treated confidentially. Moreover, no data was shared in a way that can be linked to real nurses in the settings. This was maintained by presenting participants' initials instead of their names, and the researcher declared that records and any information related to the interview would be destroyed 3 or 5 years later. The required time that data should be retained varies by facilities and funding agencies, ranging from 3 to 10 years (Steneck, 2004).

3.4.3 Autonomy

The researcher explained to the participants their role as volunteers in this study and ensured they understood their right to participate voluntarily. Also,

participants were reassured they still could withdraw at any time, and without giving a reason, their withdrawal would not affect the relationship with the researcher.

Franklin et al. (2012) confirmed participant autonomous rights; they declare that to ensure participants have the autonomous right to self-determination. Researchers must ensure that potential participants understand that they have the right to decide whether or not to participate in research voluntarily and that their access to current or subsequent care will remain the same. Self-determined participants are reflected in the ability to ask the researcher questions and comprehend the questions the researcher asks. Researchers informed participants that they might stop participating in the study without fear of penalty.

3.5 Sampling procedure

The purposeful sampling method is a technique widely used in qualitative research to recognize and select cases rich in information for the most effective use of limited resources (Patton, 2002). This involves identifying and selecting individuals or groups who are incredibly knowledgeable about or experienced with a phenomenon of interest (Cresswell & Plano, 2011). Thus, they used initially employed staff nurses working in oncology units to participate in the interviews.

The research samples were also deliberately selected to enrich the research content with the necessary information that reflects the different perspectives of oncologist nurses' experience in these areas with terminally ill patients considering the total nursing workforce is 88.

3.5.1 Purposive Sampling

The reason for utilizing a purposive sampling technique is to match the study's sample to the research aim and objectives, thus enhancing the study's rigor and the trustworthiness of the results and findings of the study (Campbell et al., 2020).

Purposeful sampling techniques are described by Patton (2002) for primary research, which has defined what purposeful sampling means, and the logic and power of purposeful sampling sites in choosing information-rich cases for in-depth study. So, those cases in which one can learn more about matters of central significance to the target of the inquiry, thus the term purposeful sampling. Studying information-rich cases yields insights and in-depth understanding rather than empirical generalization. In addition to knowledge, skill, and experience, Bernard (2002) and Spradley (1979) noted the importance of availability and willingness to participate and communicate experiences and opinions in an articulate, expressive, and reflective manner.

In this study, the researcher enlisted a purposive sampling technique to recruit Bahraini and non-Bahraini staff nurses from the oncology department despite their age, educational background, years of experience, gender, working setting, and job designation to attain perceptiveness about overall nurses' experience in the contexts of the study from various viewpoints.

3.5.2 Sample Size

Most qualitative studies are conducted initially with small samples, and some research is done on 10-respondent samples, which is considered usual in qualitative studies (Sandelowski, 1995; Lichtman, 2010). Sandelowski (1995) notices the established practice of an aesthetical principle when appraising a

sample size: "...small is beautiful". Patton (2002) recommended that qualitative research sample sizes should reasonably cover the studied occurrence, depending on the study's aim and the stakeholders' points of interest. In other words, a sample should be proper.

According to Vasileiou et al. (2018), its appropriateness is expressed by the composition's appropriateness (cases, units rich in information) and sample size (accurate data for fully explaining the occurrence – quantity and quality). Therefore, numbers are essential. Thus, sample size becomes a key consideration when assessing the output quality and reliability for qualitative research, or as described, a key quality marker of qualitative research.

Mason (2010) declared that most scholars debate that saturation is the most crucial factor to consider when mulling over sample size decisions in qualitative research (see Section 3.9). The sample size for this research was primarily 20 participants, but only 15 participants participated in semi-structured interviews, as data saturation was gained. The participants from the outpatient oncology setting were selected purposefully (one clinic nurse supervisor, the clinic team leader, and two general nurse specialists). From the inpatient setting, one senior male nurse, a nurse counsellor, four female senior nurses, and the rest six were special nurse specialists (see Table 4.1).

3.6 Recruitment Procedure

Once the researcher achieved ethical approval from the Collage of Health and Sport Sciences & SMC Research Committee and permission letters from Chief of nursing Services and Head Nurse of the Oncology department, the participants were recruited from 2nd December 2021 to 16th February 2022. Per the qualitative

approach context, the recruitment of participants during data collection concurrently with data analysis.

Permission was received from the Head Nurse of the oncology department; the researcher arranged a meeting with oncology unit Nurse Supervisors considering them the gatekeepers for this research. Gatekeepers are essential mediators for accessing study settings and participants within social research. They may be persons within organizations who have the power to grant or withhold access to people or situations during research into organizations. Furthermore, gatekeepers may comprise persons or those in charge of formal institutions (e.g., heads of institutions such as headmasters and principal officers of organizations) whose permissions are required to access critical documents or persons under their proper care (Andoh-Arthur, 2020).

Also, they were provided with comprehensive information and further explanation about the study aim, objectives, methodological interests, and their vital role in approaching a purposive participant. Four-unit supervisors and two team leaders enabled researchers to collect data, select the oncologist nurses purposively, and give them the participant information sheet and informed consent.

Recruitment started at the beginning in inpatient units earlier than in outpatient units, according to the willingness of staff nurses to participate. In the second week of the data collection process, the outpatient unit supervisor helped the researcher enter their unit to approach the participant after they agreed to participate. Supervisors in oncology departments play a significant role as gatekeepers; they facilitate easy access to the unit and mediate to ensure proper purposive samples and provide a proper place to conduct a face-to-face interview.

3.7 Data Collection Method

Qualitative data collection is labor-intensive, focused, and complex; Billups (2021) stated that: “as a qualitative researcher, you must immerse yourself in the field for sufficient time to collect extensive data, understand the context, and uncover the nuances of what is occurring”. (Billups, 2021, p.11).

Qualitative data were assembled by semi-structured interviews, and this section provides a detailed explanation method of collecting qualitative data, the reasoning for using the method, the procedure of collecting data, and the analytical approach used.

3.7.1 Semi-Structured Interview

An interview in qualitative research attempts to understand the world from the participant's point of view, unfold the meaning of people's experiences, and uncover their lived world. Therefore, it is to realize the meaning of what the interviewees say. The interviewing process aims to cover both factual and meaning levels (Kvale, 2012). Frey and Oishi (1995) defined the qualitative interview as a purposeful conversation in which one person asks prepared questions, and the other person answers with detail, depth, and nuance. Moreover, the immediacy of the qualitative interview is inherent in the interactions that allow the researcher to learn about the participant's experience by observing, listening, and gathering information that is not directly accessible (Rubin & Rubin, 2013). Billups (2021) denoted that the unstructured semi-structured interview type is typical for qualitative research projects. However, Semi-structured interviews comprise the next level of structure in a qualitative interview. Sewell (2005) summarized the semi-structured interview by noting its distinction from the

unsaturated interview; the researcher generates an outline of topics or issues that will be covered in the semi-structured interview. Tracy (2019) believed that the researcher is the instrument in qualitative studies. Given this, most qualitative researchers need only provide a list of interview questions.

For this study, a semi-structured interview was used as a data collection tool to fulfil the study's aim and objectives. Face-to-face individual interviews with oncology nurses in inpatient and outpatient settings were held. In faith of researchers to explore their perception of end-of-life care, their experience while providing care for terminally ill patients, and the impact of those patients on the quality of the care supplied by oncologist nurses.

The researcher believed in a semi-structured interview whereby the close interaction between researcher and interviewee produces a conversation with a purpose. Moreover, the researcher intends to view the oncologist nurses' world, experience, and emotions through their lens via an open and sensitive discussion that requires a relaxing, trustful atmosphere to preserve participants' comfort. The researcher anticipates interviewing participants during working hours and within their units upon previously scheduled appointments by the unit nurse supervisor. In a semi-structured interview, the participants can flexibly choose their own words, context, descriptions, and meaning regarding their experience. In addition, the researcher used an interview topic guide for a semi-structured interview to ensure flexibility, allowing her to modify the order and details of how topics are to be covered and probe to direct conversation while maintaining the participants' narrative steer.

DiCicco-Bloom and Crabtree (2006) claimed that interviews are conducted once only, with an individual or a group, and generally cover 30 min to more than an

hour. In this study, interviews ranged from 45-80 minutes with staff nurses in the spot of work either inpatient location, which is a busy condensed setting considering staff nurses giving holistic care for admitted terminally ill patients, and in an outpatient setting (short stay or daycare unit) where they're receiving terminally ill patient for counselling session, palliative chemotherapy, pain killer clinic, or follow up clinic. The researcher considered the interview topic guide and semi-structured interview protocol (see Appendix 10), as Morris (2015) stressed the importance of the interview topic guide and affirmed that developing a practical interview guide is central to conducting a semi-structured in-depth interview. Although the semi-structured interview allows digress and discuss unexpected features and sides, all the crucial topics in the interview guide should be covered. The data elicited from the questions should give the capacity to answer the research questions the researcher is investigating.

3.7.2 Interview Questions

To obtain ethical approval from UoB and Governmental Hospital (GH) research committee, the researcher attempted to design a general question for a semi-structured interview to feed the research aim and objectives. The researcher prepared a flexible, less structured interview guide to evoke discussion and open, frank conversation with participants. This was a compromised deviation from the subjectivity of addressing research questions and bias. Tracy (2019) suggested that semi-structured interviews are more flexible and organic. The interviewer enters the conversation with flexible questions and probes or with just a list of bullet points. The researcher generates four main open-ended questions and additional probe questions to cover the research topic with free varying words and sequences of questions (see Appendix 10) while controlling the interview flow. Also, the

researcher prepared an English interview guideline for both oncology settings, as the English language is the official language at SMC.

The researcher started the interview using general introductory questions to explore the participants' demographic, educational background, job designation, and general experience. Then more probing questions were asked for detailed and in-depth information. As the interview progressed, the researcher got a chance to control the process of obtaining information from participants and act as an active listener without causing a distraction to the participants. During the interview, the researcher played the role of facilitator to encourage oncology nurses and cancer survivors to talk freely and tell their lived experiences in their own words. The participants were speakers, and the researcher was a good listener during the interview (Polit & Beck, 2012). The researcher gave appropriate responses to facilitate the participant's talks and clarify issues when needed (Creswell & Poth, 2018).

During a face-to-face interview, there is a prospect of observing the social and non-verbal cues of the interviewee. These voice, intonation, gestures, and body language cues can supplement the interviewee's verbal response. They can give the interviewer cues about the interview process (Opdenakker, 2006).

Miles and Huberman (1994) and Flick (2013) suggested that even if you think you will remember a particular moment, you likely will not be able to recall each moment with sufficient detail. Therefore, interviewers should always record memos—notes about what you are learning from the data." From this point, the researcher registered a message for the participants' nonverbal comments, facial expressions, and body language for further data analysis.

During the interview, as the study handles sensitive material about exploring participants' emotions, the researcher prepared an emotional distress policy (see Appendix 11) in case of any emotional distress that she may face. The researcher did not experience any incidents where the participants experienced emotional distress or felt unwell to proceed interview; while recording, all participants showed their motivation to participate and are involved in the study.

3.7.3 Transcribing Interviews

The researcher transcribed and documented the audio interviews in verbatim form through manual transcription immediately after the completion of each interview. Once the data has been collected, the data transcription process commences (McGrath et al., 2019). The most common form of transcription in qualitative interviews is verbatim transcription, defined as the word-for-word reproduction of verbal data. The written words are an exact replication of the audio-recorded words (Poland, 1995). This experience posed a significant challenge to the researcher as a novice in the field of research. It made a researcher interact and immerse in the information to discover what is hidden between the lines and learn how to translate the interviewee's emotions, body language, gestures, voice tone, and verbal and nonverbal cues. In addition, all interviews were transcribed within 24-72 hours of interview time. Initially, the researcher started the verbatim documentation by playing the audiotape and writing it manually. All interviews were sent to the supervisor in seek of feedback. The supervisor gave the researcher feedback about the first interview to ensure the following proper interview protocol and techniques, commented on the supervisors improving the interview question format, probed for further in-depth information, and spent more than 60 minutes with each interviewee to get rich data. Moreover, to ensure the

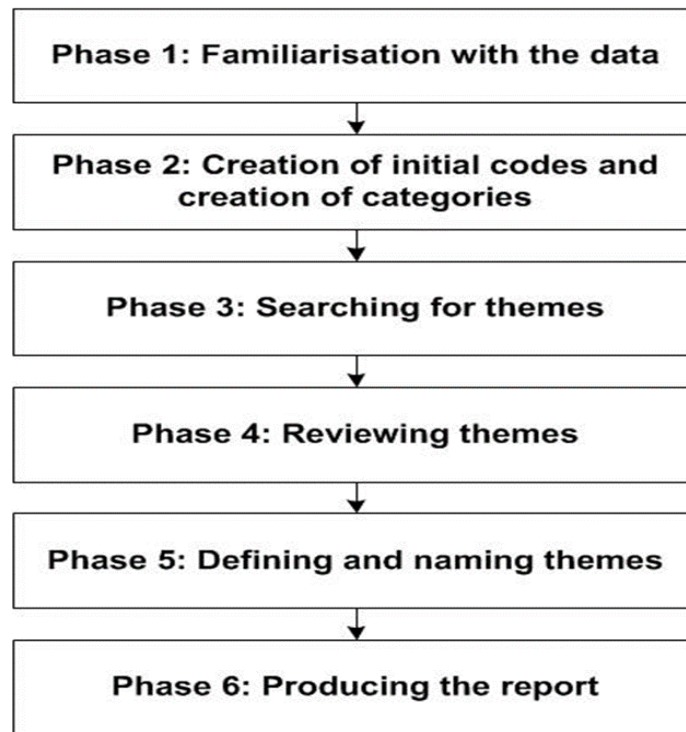
transparency and accuracy of the transcribed information, the researcher confirmed the obtained data by replaying the audio again, parallel with reading the transcribed verbatim; some words were not heard correctly, so they were modified, and notes were added. These methods helped her maintain proper documentation of interview transcription with original interviewees' statements.

3.8 Data Analysis

Qualitative data analysis is mostly a complex stage of the research process, given that no universal procedure applies to every situation (Turcotte, 2009, Dufour & Richard, 2019; Saint-Jacques, 2011). Lochmiller (2021) believed that qualitative research is a diverse field that employs various analytic techniques to synthesize an understanding of rich datasets. Lochmiller (2021) suggested that among the more popular techniques used by researchers, thematic analysis involves the recognition of recurring patterns that researchers as overarching statements or themes present. Clarke & Braun (2013) emphasize the patterns in the data that are important or interesting and use these themes to address the research or say something about the issue.

According to Braun & Clarke (2006), the data analysis process in the thematic analysis is under the classifications of generating initial codes, defining and naming themes, reviewing themes, and searching for themes (Diagram 3.1).

Figure 3.1: Braun & Clarke (2006), the data analysis process



The researcher approached data in an interactive process; data analysis started earlier, concurrently with the data collection process, by using thematic analysis as it is an accessible and flexible method that helps the researcher to see and make sense of the experiences of oncologist nurses while providing care for terminally ill patients. So, this section will explain the process of formulating an initial coding after being familiarized with verbatim transcribed interviews, searching for themes, reviewing themes, defining and naming themes, and lastly, writing up the report. Before and during each data analysis process, research supervisors reviewed the steps to ensure the trustworthiness of information and maintain rigor. The interview was analyzed by the researcher initially, the first cycle of coding was done, and the supervisor's role was to supervise and keep the researcher on

the proper track; after confirming the correct initial codes obtained, the researcher moved to the next step which is searching for an initial theme.

Initial themes were confirmed by supervisors and merged into the final theme and subtheme. Afterwards, supervisors guided the researcher to the last data analysis step: reporting results and findings.

3.8.1 Familiarity

Processes of thematic data analysis begin with the phase of familiarizing with the data, and the researcher is expected to transcribe the interview and obtain a sense of the whole by reading the transcripts several times. At the same time, the thematic analysis researcher is mainly advised to consider both latent and manifest content in data analysis (Vaismoradi et al., 2013). Braun & Clarke (2013) identify this as "analytical sensibility," which refers to the skill of reading and interpreting data through the chosen theoretical lenses. Therefore, reading, re-reading, and keeping records on noticeable aspects (for example, in interview data, there can be specific quotes that directly represent concepts in theory; or else, there can be quotes that you never expected, showing emerging patterns) of the data must be done in the data itself (as a note below or above the quote or as a footnote) or in a separate document.

Furthermore, the verbatim transcription is printed as a hard copy to transcribe interview data. The researcher turns on and plays the IC for a while to become familiar with the conversation, then types what is heard and rewinds it to make sure to get all the data. The researcher proceeds slowly through printed data to register unspoken words and observations noticed during the interview. Moreover,

this process is not straightforward as researchers consume 3 to 6 hours to modify and correct each interview.

In this phase of the study and after verbatim transcription of the interviews, the researcher went through each interview several times and read and re-read the transcriptions to extract the main idea, make sense of the issue of her research, and familiarize herself with the data corpus. Moreover, supervisors advised the researcher to read the transcription several times and reflect on each statement to prepare the researcher for the next step of the data analysis, the coding phase. Lester & Lochmiller (2020) stated that the printed verbatim transcribed interviews yet, transcription serves as an opportunity to become familiar with a data set. This familiarity deepens a researcher's understanding of the participants' perspectives and supports them in understanding the data set in a way that accelerates analysis later.

3.8.2 Generate Initial Codes

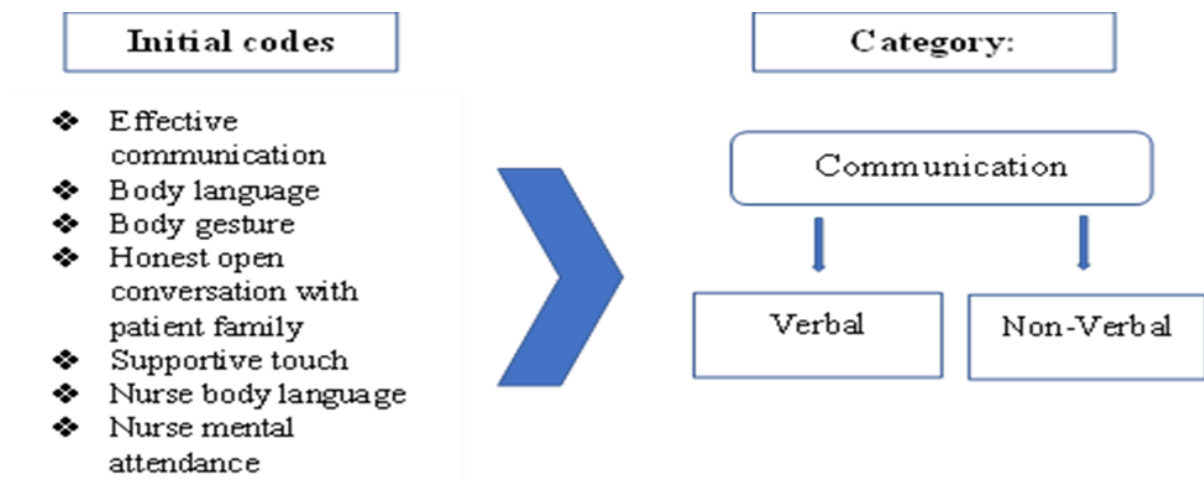
Qualitative analysis codes are often a word or a short phrase that symbolically assigns a summative, silent, essence-capturing, and evocative attribute for the portion of language-based or visual data (Saldana, 2021).

According to Saldana & Omasta (2018), the first cycle of coding is analysis-taking things apart; the second cycle of coding is synthesis- putting things together into new assemblages of meaning.

In this phase of the analytic process, the researcher transformed the data from a massive form to a small chunk. The researcher applied one code to what the participants themselves said and placed it in quotation marks (Refer to Figure 3.1). The initial coding cycle is accomplished for each verbatim transcribed sentence

from the recorded interview, observation, and notes added at the interview's time, meaning the researcher met the semantic codes. These semantic codes are the emerging data (random interview quotes identified in the previous stage) and can be labelled with a name derived from the data. When such codes are identified, it is necessary to include them in the list of codes. Likewise, the list of codes can be expanded with emerging data-driven (semantic) codes (Bryant & Charmaz, 2019).

Figure 3.2: Example of codes to categories



The coding process initially started manually on a hard copy verbatim transcript, then later was converted to a schedule on a computer using Microsoft Word (Version 2016). Each statement from the data was defined and conceptualized and given a number. Then all concepts with their numbers were listed in the schedule under the codes column in a table that included all concepts obtained at the initial coding phase/cycle. The initial coding cycle of the primary interview data generated 116 initial concepts which were explanatory. An example of the (semantic–latent) initial coding process is provided in Table 3.1 (See Appendix 10).

3.8.3 Identifying patterns: Codes to Themes (sub-themes and themes)

Braun & Clarke (2013) stated that a pattern-based analysis allows the researcher to identify salient data features that are meaningful in answering the research questions. In identifying which patterns are the most relevant for answering a particular research question, the frequency of appearance of a specific code is important. Nevertheless, some codes would not frequently appear but are meaningful for answering the research question. Therefore, the frequency and how vital a particular code is to answering the research question are also to be considered at the stage of identifying patterns in the data. Braun & Clarke (2006) explained that there are no hard and fast rules about what makes a theme. A theme is characterized by its significance. It is rarely found themes at this stage, and recommend that researchers progress through the second coding cycle as recommended by Saldaña (2015). Again Braun & Clarke (2006) explained this phase by collating codes into potential themes and gathering all data relevant to each possible theme.

From this point, the researcher refined the codes again and tried to collate the relevant codes with each other to create a preliminary theme. Also, some codes are associated with more than one theme (see table 3.2, Appendix 11) and figure (3.1). Also, the researcher attempted to sort the similar codes under sub-categories and then main categories and to define the preliminary ideas which can connect the collected data to answer the research questions within the context of research objectives and aim in a logical chronological sequence and help the researcher to move forward to the next step of data analysis procedure which is reviewing themes (see section 3.8.4).

This phase of checking if the themes work concerning the coded extracts and the entire data set generates a thematic map (Braun & Clarke, 2006). The researcher attempted to review, modify and develop the preliminary themes that the researcher identified in the previous phase, "searching for the theme" (see section 3.8.4), and gather all the data that is relevant to each theme by assigning a color code for each theme, she used a Microsoft word to create a schedule divided into columns for each theme as mentioned previously. Different color was assigned a for each theme, as well she utilized 'cut and paste function in any Microsoft Word 16. Again, the researcher read the data associated with each theme and considered whether the data did support it. Then, I tried to see whether the themes worked in the setting of the entire data set. From the data set aspect, the researcher attempted to contrast the themes and considered how the themes reflected a single interview across all the interviews (See Table 3.2- Appendix 11).

3.8.4 Searching, Reviewing and Finalizing Themes

According to Braun & Clarke (2006), a theme "captures something important about the data related to the research questions and represents some level of patterned responses or meaning within the data set" (p. 82). These patterns are broader than the codes because they contain many facets. These authors further state that a theme is "central (Braun & Clarke, 2013, p. 224), which is a collection of codes and is thus a collection of ideas or aspects that can be recorded under a specific theme.

This phase of checking if the themes work in relation to the coded extracts and the entire data set generates a thematic map (Braun & Clarke, 2006). The researcher attempted to review, modify, and develop the preliminary themes identified in the previous phase, "searching for the theme" (see section 3.8.3), gather all the data

that is relevant to each theme by analyzing the given responses, classified parallel answers under specific categories, and correlated concepts were unified under a certain theme.

Braun & Clarke (2013) stated that the researcher should note a few points at this stage. Firstly, the themes identified at this point might be provisional and subject to change under a supervisor's advice, or the researcher, him/herself, may recognize that the identified themes do not match the research questions. Therefore, Braun & Clarke (2013) encouraged revising identified themes if required. Secondly, themes do not have to cover everything in the data but instead have to be selective because qualitative research presents a story about the data in a way that addresses the research questions. Supervisors of the researcher review the subthemes, main themes, and set of data that emerge under the theme of each theme and examine the data, whether sorted in proper track and reflects the entire context of the study and gives a logical answer to the research question leading to a comprehensive finding of staff nurses' experience with the terminally ill patient from their lenses (see table 3.3 Appendix 12).

An example is elucidated in figure (3.1); all codes extracted from interviews about communication with the terminally ill patient revealed that those sub-categories (sub-themes) were verbal communication and non-verbal communication, which can be categorized under one broader theme "Open, trust, and compassionate communication skills of a nurse. According to the last of finalizing the theme, and under supervision with the research supervisor, the "Open, trust, and compassionate communication skills of a nurse" converted to "Intra and interprofessional communication" and considered as a sub-theme under a second main theme entitled as "factors influencing nursing care."

6.8.5 Writing Findings and Developing the Analysis

Researchers have been spending much time already in the analysis of data. Each provisional theme and related data collected through codes have now to be presented to tell the story of the data in relation to the research questions. This story can be presented in two ways: either in a separate chapter, combined with relevant literature and the theories of the study in a later chapter, or else the story/findings can be presented directly by integrating it with theory and past literature (Bryant & Charmaz, 2019). The data analysis findings will be discussed in chapter four (See Section 4.2).

Qualitative researchers must understand that there can be analytical differences according to the different perspectives and theoretical influences of different people. A supervisor or a co-researcher may see those patterns in different ways.

Important to be noticed there is no correct answer to the research questions in a qualitative study; instead, researchers have to always look for the best fit of the analysis to answer the research question/s (Bryant & Charmaz, 2019).

3.9 Data Saturation

In qualitative research, saturation is used as a criterion for terminating data collection and analysis (Garrett et al., 2012; Lipworth et al., 2013). Morse (2015) declared that saturation is the most frequently touted guarantee of qualitative rigor offered by authors.

Qualitative methods place primary emphasis on saturation (i.e., obtaining a comprehensive understanding by continuing to sample until no new substantive information is acquired) (Miles & Huberman, 1994). The researcher considered the data collection process and data analysis process simultaneously, but through

the data collection process from the fifth interview, the researcher noticed the occurrence of new data about the effect of cultural diversity on oncologist nurses' experience, so probing questions were modified to fulfil the context of research, with data analysis. Later, saturation was achieved when no new concepts or main categories and sub-categories appeared from the data analysis of interviews, which means the categories and sub-categories were well classified, defined, and conceptualized. The saturation decision to discontinue data collection and analysis depends on the outcomes. So, the decision was taken upon reviewing the emerged data from data analysis, reading the transcripts and written memos several times, and sharing and reviewing the outcomes with supervisors. The final decision was approved, finalized, and confirmed with supervisors; data collection and analysis were stopped after data saturation was achieved. The saturation was accomplished after 15 interviews.

3.10 Rigor of the Study

As Polit & Beck (2012) reported, Lincoln and Guba developed four quality criteria for qualitative research's trustworthiness: credibility, dependability, confirmability, and transferability. They explain further that credibility refers to confidence in the truth of the data and their interpretations of them. Dependability refers to the reliability of data over time and conditions. Confirmability refers to objectivity, that data represents the information participants provided and that the researchers do not invent the interpretations of the data. Transferability refers to the extent to which the findings can be transferred to other settings. For the sake of trustworthiness, the researcher adopts Lincoln and Guba's stringent criteria.

3.10.1 Credibility

Indicates confidence in the truth value of the data and its interpretations. Qualitative researchers must strive to establish trust in the truth of the findings for the particular participants and contexts in the research (Lincoln & Guba, 1985). To establish confidence that the results (from the perspective of the participants) are valid, credible, and believable (Lincoln & Guba, 1986). Credibility is amplified through different strategies; the researcher spent an average of 6–8 weeks within the oncology department to engage with participants, interview protocol, and mattress tested at induction meetings with two research supervisors using the first interview as a pilot interview during the first supervisory meeting which held on 18/11/2021 before data collection. The researcher shared an interview verbatim transcript with supervisors attached with field notes; to ensure the intactness of data collected and analyzed for initial codes, sub-categories, and themes. Also, the researcher and supervisors had regular debriefing meetings to confirm the flood of data collection and analysis process as it co-occurs in this research. Furthermore, the researcher credited the principle of summarizing interview content with participants to emphasize the appropriation and clearness of data gained during an interview and documented field notes for non-verbal comments.

3.10.2 Transferability

Transferability denotes the generalizability of the inquiry in qualitative research, which concerns only case-to-case transfer (Tobin & Begley, 2004). The researcher cannot know the sites that may wish to transfer the findings; however, the researcher is responsible for providing thick descriptions so that those who seek to transfer the findings to their site can judge transferability (Lincoln & Guba,

1985). Transferability is accomplished when the researcher can communicate the impact of research findings by crafting aesthetic representation, which spurs audience members to imagine and personally transfer research illuminations to a range of familiar contexts (Tracy, 2019).

The researcher employed participants with distinctive features, e.g., different social backgrounds, educational qualifications, and variant years of experience in oncology departments and other departments (medical, surgical, & intensive care units), for transferring research findings to another care setting where health care provider delivers care for noncancer terminally ill patients.

3.10.3 Dependability

To achieve dependability, researchers can ensure the research process is logical, traceable, and clearly documented (Tobin & Begley, 2004). When readers can distinguish the research process, they can better judge the dependability of the research (Lincoln & Guba, 1985). One way a research study may demonstrate dependability is for its process to be audited (Koch, 1994). The researcher supported her research by maintaining dependability through detailed information which illustrates the data collection method and data analysis process, also as limitations and obstacles faced throughout the research generating period.

3.10.4 Confirmability

Confirmability is concerned with determining that the researcher's interpretations and findings are derived from the data, enabling the researcher to illustrate how conclusions and interpretations have been reached (Tobin & Begley, 2004). According to Guba & Lincoln (1989), confirmability is established when credibility, transferability, and dependability are achieved. Koch (1994)

recommended that researchers include markers such as the reasons for theoretical, methodological, and analytical choices throughout the whole study so that others can understand how and why decisions were made. Before beginning the interviews with the participant, the researcher established an approachable relationship to create an intact, comfortable, and trusting atmosphere enabling her to collect data successfully; also, post each interview researcher summarized the conversation with the interviewees. Through the data analysis process, the supervisor advised the researcher to analyze each interview individually with contentious debriefing and guidance. Research and discussion carried out step-by-step with supervisors to avoid internal or external bias may be presented to researchers.

3.11 Chapter Summary

This chapter describes the method and methodology adopted for this research for data collection and analysis, which is an exploratory qualitative method. The data analysis process utilized Braun & Clarke's (2006) model for thematic analysis. Moreover, the trustworthiness and rigor of the study-maintained step by step under the supervision of researcher supervisors. The next chapter discusses the findings of the research.

Chapter IV

Findings

CHAPTER FOUR: FINDINGS

4.1 Introduction

This chapter shows the findings of the qualitative data analysis. The data provide an understanding of the context of staff nurse experience while providing care for the terminally ill patient in oncology settings (inpatient and outpatient) in Bahrain at Salmaniya Medical Complex (SMC) and explore the thoughts, perceptions, practice, and experience of staff nurses involved in the direct care of cancer terminally ill patient.

The first section of this chapter targets and highlights participants' demographic data obtained from participant sheets and semi-structured interviews (see section 4.2). The following section (4.3) presents the findings of qualitative data analyzed according to Clarke and Braun's (2006) 6th step of data analysis: writing up the result from the derived themes and sub-themes. Thus, the participants' quotes and nonverbal comments were included to support findings and maintain a logical flow of the research content. Also, to fulfil the aim and objectives of the research for exploring the oncology nurses' experiences while providing care for terminally ill patients at SMC. Moreover, participants' words and statements were involved, and quotation marks in italic were added to brackets and used to clarify the meaning of some words or statements.

The participants were also given numbers to preserve their confidentiality and anonymity.

4.2 Participants' Demographic Data

Qualitative data were obtained from 15 semi-structured interviews examining the demographic data of 15 oncology nurses included in the study.

The participants' working experience ranged from less than three years to more than 15 years, with a mean of 16 years. Their nationalities are Bahraini (n=10) and Indian (n=5). Among the 15 participants, one was a male nurse. Participants had different positions, but most were specialist nurses (n=10), with a mean age was (38.3). A summary of the participants' demographics (age, gender, nationality, position, and marital status), years of working experience, and highest qualifications obtained are presented in Table 4.1.

Table 4.1 Nurse Participants Demographic Data

ID	AGE	SEX	POSITION	NATIONALITY	WORK EXPERIENCE	MARITAL STATUS	EDUCATIONAL LEVEL
P1	45	F	Senior Nurse	Indian	18 Years	Married	Diploma
P2	47	F	Nurse Supervisor	Bahraini	25 Years	Married	MSN
P3	31	F	General Nurse Specialist	Bahraini	6 Years	Married	BSN
P4	40	F	Senior Nurse	Indian	18 Years	Married	Diploma
P5	51	F	Nurse Supervisor- Counselor	Bahraini	29 Years	Married	MSN

P6	42	F	Special Nurse Specialist	Bahraini	21 Years	Married	BSN
P7	33	F	General Nurse Specialist	Bahraini	9 Years	Married	BSN
P8	43	M	Senior Nurse	Indian	22 Years	Married	Diploma
P9	48	F	Senior Nurse	Indian	26 Years	Married	Diploma
P10	26	F	General Nurse Specialist	Bahraini	4 years	Married	BSN
P11	37	F	Senior Nurse	Bahraini	i Years	Married	Diploma
P12	33	F	General Nurse Specialist	Bahraini	11 Years	Married	BSN
P13	29	F	General Nurse Specialist	Bahraini	7	Single	BSN – preparing for MSN
P14	39	F	General Nurse Specialist	Indian	18	Married	MSN
P15	31	F	Special Nurse Specialist	Bahraini	10	Single	MSN

BSN = BACHELOR OF SCIENCE IN NURSING

MSN = A MASTER OF SCIENCE IN NURSING

4.3 Findings

Analyzed data exhibited the experience of nurse participants, which has been collected and categorized according to Clarke and Braun's (2006) thematic analysis. The themes and sub-themes emerged during data analysis. Researchers analyzed the given responses, classified similar answers under specific categories, and gathered and interpreted them within the frame of certain concepts and themes. The correlated concepts were unified under three specific main core themes and eight sub-themes. The research findings revealed three key themes that emerged from thematic analysis: (1) exhausting versus rewarding experienced feelings presented in two sub themes positive feeling and negative feeling ; (2) factors influencing nursing care designed from three subthemes which are nurses' characteristics, patient characteristics, and intra and interprofessional communication; (3) Moral Distress the last theme includes also three subthemes: management ethical issues, inadequate quality of care family caregiver role.

The qualitative findings are presented in the following sub-sections according to three main core themes and eight subthemes that emerged.

4.3.1 Exhausting versus rewarding experienced feelings

The first theme gained from analyzed data is the exhausting versus rewarding feeling that staff nurses face and experience while providing care for terminally ill patients. Emotional exhaustion is known to occur when a nurse experiences a period of excessively stressful situation leading to fatigue, being overwhelmed, and being emotionally drained. On the contrary, staff nurses' emotional rewards are expressed through acceptance, appreciation, respect, and satisfaction.

Therefore, sub-themes dragged from this main theme to comprehensively explain their experience and describe the exhausting experience as a negative and rewarding experience as a positive feeling.

4.3.1.1 Positive feeling

This sub-theme helped to express different feelings about caring for terminally ill cancer patients. The analysis of the participants' verbatims verified that the participants reported positive feelings related to the nurses' practice, emotions, performance, and experiences while providing care for terminally ill patients.

Sympathy, compassion, and empathy arose in the participants' dialogues since the terminally ill patients remained hospitalized for an extended period and attached to staff nurses, predominating feelings resulting from this frequent contact with the patients, families, and team making them perceived as terminally ill patients as family members.

“Because daily... if they will take chemo (terminally ill patients) after 21 days after. Two weeks they will again come to this only (they will come ward) ... because like family... like that. We are like family community here. Okay, that's a family community.” (P1)

“So, as a female when we are looking after lady's [female patient], we felt more empathetic to them. Because we think of ourselves in their place when they're crying for their children, we think of our children. If we are in her place like this, our condition, but we will like that, we were showing too much empathy.” (P4)

“Patient being admitted for a prolonged period... we will use to them...some will ask for the staff by name for help...we only like a family here.” (14)

Sympathy and emotional labor are the methods used by some participants to manage their feelings and expressions to achieve the dynamic requirements of a working setting with terminally ill patients and stay emotionally detached. Also, specifically, some participants regulate their emotions during interactions with terminally ill patients, the nurse team, and supervisors, so that quoted from some participants:

“But as soon as we cannot express our feelings like sympathy, no, we cannot show sympathy towards them. We have to show everybody okay, and we should accept them.” (P9)

“I will keep my emotional side even with my colleagues. Also, this give me like even if I am working with colleagues, I will keep my emotion side even if they are my friend ... my friends outside the work... in work sitting, I will treat them as a colleague.” (P3)

Self-development results from a contentious sense of a need for self-improvement initiated from continuum contact and attachment with terminally ill patients, which involves changing behavior, leading to progression that alters work skills, attitude, and daily social living.

Thus, self-development occurs through different mechanisms as described by participants, some verbalized the self-development as a personality maturation, which means the impact of their experience with terminally ill patients made them more realistic about the nature and facts of life, so they became more mature,

valuing the family, and beloved person. Viewing life as if there is nothing worthy to upset or fight for. Furthermore, personality maturation, as described by other participants in the changes that caused an alteration of their personality and improved after they worked with the terminally ill patient; they became able to contact patients and give more care and love to family, friends, and beloved people. They express their love, affection, and emotion to show their love and value for the people and everything surrounding them after seeing how terminally ill patient lose their life and family.

This improvement and alteration by participants quotes’:

“I feel that much mature now, valuing things valuing the patient's surrounding you, even the decision you will make; it won't be as fast as it was... the hole you have, your faith will be more you know that you will not focus in little little things. We're not gonna go to matter of fact, unless you're sorry, because we see that lives our patients, people are going leaving their family loved ones. And being in that situation, you feel nothing more than this life it's good.” (P2)

“I was actually stuck or not stubborn fastly ever get angry like that I was before, but suddenly I will be cold, but after this one (She means after working with terminally ill patient), I feel I... I find myself that I got more patients than I got more positive attitude”. (P14)

But for my emotion, of course, it made me more strong or more prepared for anything in this life. So, expecting any behaviour or any anything from any people will not cause you a shock.” (P3)

Another aspect of maturation and self-development, three nurses reported advising others to enjoy life, as they see life as too short to be spent in sadness, rivalry, and hostility.

“When I see patient dying and going... I think... nothing is worthy, I advise everyone to be happy not getting upset with anything.” (P7)

“My personality today differs than 14 years back, now I will not cry, I become very strong, I can face issues, I can take a decision.” (P11)

“Advising others to enjoy life) even it helped me to change my life after working the palliating on it because I don't know what happens the next day, so I want to be always play calm and smile and give my the fullest to the daily life.” (P1)

Another mechanism that indicates self-development and positively impacts the participants verbatim is nurse adaptation to the challenging situation. They learn from hard and sensitive work with the terminally ill patient to be extended and reflected from work environment to family and social life. So, they became more aware of solving the problem, owning critical thinking, tolerating pressure, and finding a way to express their feeling and emotion to a very close person.

“By the time, I really not like... aaa... I really love the area, adaptation, it tooks me around almost two years, I really face some difficulties some conflicts with patients.” (P2)

“I trained myself to separate this emotions to separated somehow or even if I have some of inside my inside myself. I tried my best to not show it to others. But even sometimes in front of your colleagues some of... some of...aaam... my position, it will restrict me to show my feelings. So, you

have to be for example, strict or strong in front of your employees. So, the team will be also strong.” (P2)

“When I was having like emotional or physical or any work distress, I would go to the senior more senior staff or my supervisor or my team leader I tried to express I want to see what what did I do things correct or what did I do wrong? I went to correct things more I went to an actual experience with them because they know more regarding this type of situation.” (P3)

“sometimes having good support people this one it will have even even if it if this person is one of your employee for some you know from from our life situation you will find someone who has good effect on you maybe I'm not verbalising who's that person, but sometime when I am drained emotionally, you will see me sitting with that person because that person is giving me positive vibes vibes or he can, or she can distract me from the situation, so I will take myself out of the situation by distraction enjoying an another activities with other persons like that I'm controlling myself.” (P2)

Moreover, the positive impact of working with terminally ill patients is described as the best course of action, which means throughout participants' experience with terminally ill patients let them provide a high quality of care, for good patient outcomes resulting in fulfilling patient wishes, pain-relieved, high quality of end-of-life treatment, and dignified death.

Thus, it was found from the majority of participants' points of view and their verbatim words:

“I want to send patient to peace; I don't want patient to suffer anymore. I don't want patients to feel pain, how to give the correct palliative care support care and urgent care support? I want them to feel comfortable at their last moment. I don't want them to feel pain. I don't want them to feel. (P3)

“Palliative care, according to me means once cancer starts and it is the end of the life, we want them to prepare for a peaceful that. According to us, we want to leave them without any pain. And we want to give them a peaceful death. And we want their relatives also to accept that this is what is going to happen.” (P4)

“But they need pain management to treat the pain first then psychological support spiritual support like a holistic approach or to view the family and the patient.” (P9)

“I think best management for dying patient is pain controlling, spiritual and psychological support by mullah or Quran, give patient whatever they want.” (14)

“I want them to feel like... I prepare the patient their last days to stay at home. Personally, I prefer that because they want the family surrounding them sometimes the idea of dying get hospital to like to make more stress for this type of patient or any, I think they need emotional support from their family more than from us [nurses].” (P3)

Also, some participants considered that appreciation from terminally ill patients, their families, and work teams can give satisfaction. Forward, this satisfaction

impacted them positively to be motivated more to give a high quality of care, even for the best course of action, as revealed by P6 in the following quote:

“I will feel relief if the patient or families smile and tell me thank you.” (P6)

“We expect from patient and family to understand we are under pressure.” (P8)

Additionally, working with terminally ill patients enhances the sense of creativity of staff nurses, improving their performance to activate the occupational therapy measure for a terminally ill patient. They viewed occupational therapy as an opportunity for thought diversion for those patients, stimulating both staff nurse and patient for productivity and diverting from end-of-life situations to inspire and improve daily life activity.

“We have a creation room, we always encourage patients to do handcraft. Amm like drawing.. sometime patient will gather in this room and will talk and share their experience.” (P9)

“Also, that is that comes in psychological support and the same patient they are interested in okay some occupational thing that when somebody so many patients there they draw here so many patients will draw something and they will give us, drawings teaching all these things they will do.” (P4)

4.3.1.2 Negative feelings

Oncology work life takes up an essential place in staff nurses' life, which respectively influence their experience to be considered exhausted experience as described by research participants.

Most nurses felt that caring for terminally ill cancer patients was emotionally demanding, strenuous, and stressful because of the extensive physical and psychological pain that patients experience. This was confirmed by participants who considered their experience exhausting when they felt emotionally drained. A heavy burden was left on them because this experience required physical, psychological, mental, and holistic care and effort by nurses for terminally ill patients, their families, and team members.

"I will see the patient coming walking to take treatment, he will have treatment, he will have a tough time then he will recover... again he will collapse this on and off seeing patients the journey he is going through and the upset event he faced with him only even his family it's it was a burden for us really, and this burden as a human being at the beginning." (P2)

"it was very difficult because we are receiving a palliative care patient terminally ill patient and a very weak and every day there is the declaring of death. So, we all were mentally upset." (P4)

"seeing patients... the journey he is going through, and the upset event he faced, with him only even his family it's it was a burden for us really, and this burden as a human being at the beginning." (P2).

When the stage progress and disease progress in that time, they will come faster they came walking received chemo very happy when to home, then finally they will come become unconscious, and they will die in front of us that emotion in that situation that it is very difficult for us to tolerate. Because as a nurse, we know emotional stability is a must for us. So, we will never cry in front of the patient. But going home, we will tell our family that happened. My heart is broken like that.” (P4)

Caring for terminally ill and dying patients is a sensitive situation leading to tremendous anxiety for staff. The staff’s feelings about death can also have an impact on how they deliver care. Thus, they were described as trapped in bad memories by participants. Ghosts of unforgettable memories negatively impacted participants, which handled this burden for several years.

Most participants expressed their trapping in bad memories through these dialogues:

“The impact is still there. I because you know this incident...I couldn't forget it because it's still I remember the face of that man who his turn into flesh. I feel that: how you dare telling me that my kids cannot see my wife [husband of terminally ill patient], and he was like begging me, and I couldn't understand the importance of having family around the dying patients.” (P2).

“we have one patient.. very beautiful and lovely, was in room 18... she is with Ca breast...during covid-19 she expired because she is neutropenic because of chemotherapy... till now if I will go that room I see her, her scarf, where she is setting.’ (P1)

Another negative impact of participant speeches is feeling or a sense of guilt. This sense arose when staff nurses could not provide the care that the terminally ill desired or fulfil their last wishes like meeting their family members or dying in the home surrounded by family and remaining pain-free.

“I feel shy of myself... guilty... I put myself on his shoes, will I accept that? Totally no. And with my experience now year by year, I feel more guilty because I realise the importance of that I cannot forgive myself.” (P2)

“Sens of guilt killing me..I did not accomplish patient last desire... she want to see her small baby.” (P12)

In addition, participants' words expressing their experience as exhausted are futile treatment opportunities. When staff nurses failed to deliver holistic, high-quality care to relieve the suffering of a terminally ill patient. Here, the opportunity for a cure is less and supportive treatment care is appreciated.

“in this stage, we need to give full support to patients, but sometimes patient suddenly collapsing because of pulmonary embolism, we feel like shocked and helpless we did not save patient in proper time.” (P14).

Burnout expression reflected the negative feelings participants experienced while providing care for terminally ill patients. The workload for participant dramatically expanded as more patients was required to be cared for beyond the standard nurse-to-patient ratios. Seeing terminally ill patients suffering and dying and participants being helpless, generates the feeling of anger, compassionated fatigue, and burnout, when the stress overwhelmed the participant. The nurses described their burnout as an outcome of their patients' emotional demands and poor prognosis and care outcomes.

Unfortunately, this burnout extent affects participants' family members, as some participants verbalized that:

“if I will see the patient especially for a long time he will be admitted in the world. And he would see him through the through the disease process, when he diagnosed when he received the chemotherapy for example, and after the finally become very sick and very I will feel really sad. And this may affect me till home, I’ll teel my family we face.” (P7)

“I controlled my emotion at work. I go home I get angry with my daughter and wife.. seeing dying patient to much stressful, also less staff in shift.” (P8)

Furthermore, the discrimination feeling let the nurse participant feels negative and described her experience as:

“Some patients will treated differ than other as they are VIP, they will keep then in privet room, with privet nurse.... I don’t like this discrimination; all patients need equal chance of care.” (P3)

“When it comes to assignment distribution, always my incharge will give me a heavy assignment with sick patient.” (P7)

Participant verbalized their intolerance to seeing their patient who had a long disease journey dying and suffering in front of them.

“But yes, between us, especially the patients who will be with us for a long time. We will know them we will know their family, we have...will have fun time together. So, it's really difficult, especially when it's young patients.

This is the most difficult for seeing young patients suffer suffering. Somebody surviving and somebody going.” (P2)

“I saw some of my colleagues, they will have like a personal relationship, because sometimes patients from going on frequent time frequent admission they will build a rapport with them sometime this rapport will be very strong. That stuff some of them they cannot tolerate the situation that patient he is having. For example, He will be like terminally ill, they cannot face it. So, I will see them that collapse crying They cannot face some of nurses even they escape from the world really escaping escaped from because they cannot confront the situation or they cannot handle the emotions of their emotions and their family or emotion or the patient .” (p2).

On the other hand, some participants lost their emotional stability and cried if their patient died as stated by some participants:

“As a human being at the beginning, we couldn't separate it from our life, we were carrying... these emotions even at home, I will feel sad for, example at the home my husband or my kids, they will feel it really ...Yes, I will take it to home.” (P2)

“And sometimes I really cry and some patient, I will become too close with them close to their family, I will join them in their grieving days”. (P7)

“I remember I just cried once. About patient he was 15 years old. Mm...and he was a survivor of osteosarcoma when he was a child. So, after he cured from osteosarcoma, he .. he developed AML [type of leukaemia], and he was very sick. I didn't expect him he...will die, he was fine, just

deteriorating suddenly. I didn't think that night that we will lose that patient and we lose him because of sepsis not because of that.” (P3)

and some withheld their emotion in front of relatives. Still, between themselves (with other staff nurses) or at home, they will share the story and cry about losing the terminally ill patient as stated by the participant:

“we have to be professional with relative... we can't cry”. (9)

“it is a must to maintain our stability.” (P4)

“of course, we can't cry in front of relative... we will go kitchen, and we will cry if patient die.” (P7)

It is found that some participants felt disappointed when their efforts and care are not appreciated by patients and their families. Despite this feeling, the nurse felt broken from the inside, but there was no choice other than to work for terminally ill patients, which affect the quality of care delivered to those patients.

“I want to work in oncology, but not to give palliative patient care. At that time. I don't know what the oncology patient. So, all it was in my mind was that oncology patient with a cure. But what was the surprise when I came here (she means to work with terminally ill patients)?” (P13)

A nurse participant denoted the negative impact and feeling they experience when providing care for terminally ill patients as narrated:

“Have pain, I'll think I have the same to the patient's disease”. (P10)

“If we haven't pain in abdomen we will think of stomach cancer if there essentially any lymph node we will think of leukaemia like that the

perception become like that. And if weight loss we will, if any bowel changes in bowel movement.” (P4)

4.3.2 Factors Influencing Nursing Care

4.3.2.1 Nurse characteristics

Research participants expect to find the most significant employment opportunities in the general medical unit, surgical unit, intensive care unit, cardiac care unit, or even Very Important Person (VIP) ward which is a multispecialty unit, and few of them mentioned their desire to work in an oncology unit. However, the work environment in SMC offers limited employment opportunities for nurses at all practice levels in a variety of settings (outpatient or inpatient).

Moreover, nurses recruited in the oncology department came with personal and professional pros and cons. The participants’ tendencies and desires varied, but their functions were essential for productivity and improving health organisations. However, nurses participants’ perspectives regarding acceptance to work with terminally ill patients commenced and tend to be positive from their viewpoint, as commented by several participants in many interviews:

“I want to work in oncology, but not to give palliative patient care at that time. I don't know what the oncology patient. So, all it was in my mind was that oncology patient with a cure. But what was the surprise when I came here (she means to work with terminally ill patients)?” (P13).

“We should be more empathetic, we should be modelling, we should be a good listener, and we should involve their families. And we will say we

should be a mediator to the doctor and between the doctor and the patient.” (P8).

“I chose oncology based on patient and oncology Ward because so many Stuff they don't want to work here okay... Because of the situation... dealing with the cancer patient chemo, radiation terminally ill patient longest day it was difficult to see haematology cases, but I was happier that I will work in this area.” (P11)

“My colleague must show open-minded, strong personality. go with emotionally but stable emotion, [...] updated knowledge updated knowledge regarding the disease itself regarding the multiple lines of treatment.” (P3)

Oncology nurse characteristics play a crucial role, which helps enhance their experience with terminally ill patients. The researcher while analysing data gathered through interviews, agreed with Benner (1984), who initiates the first model to explain the differences between experience and expertise among nurses. Also, he noted that several years on the job in the same or similar situations may generate competence; however, time passage and occurrence of events and interactions do not automatically confer expert status.

“I did my master’s degree research with palliative team, I like being there, also I can call it a golden day, we create a home visit program, and hotline services.” (P2)

“Actually I’m working here now for 16 years, okay... 14 years with oncology patient (2 years at Accident Emergency). Actually, I made job

training in oncology ward where I am working recently... I interested with the case and caring of patient while I am a student.....” (P11)

It is important to note that the years of participants' clinical experience as nurses range from 5 years and more, implying that the participants must have experienced work situations in other units before being posted to the cancer unit. Participants mentioned that professional fulfilment was achieved through long years of experience, prolonged contact with terminally ill patients and helping them cope with severe medical and social conditions. The participants' opinions on their years of experience are commented on and quoted:

“I joined the service since 1996, I joined in medical wards. Then after one year, I shifted to the oncology department. [...] I worked there from 1997 till 2010. Then I shifted to the clinic, currently, the supervisor of the oncology clinic.” (P2)

In addition, motivation to work with cancer terminally ill patients is contributed by several motivational factors that may generate job satisfaction among research participants. Moreover, satisfaction levels have significantly influenced them to be motivated and interested.

Thus, that motivation is associated with their experience during student job training or prior work experience in an oncology setting at different hospitals. And other participants described their passion for working with terminally ill patients as self-preference or the importance of helping hopeless, weak, terminally ill patients.

I tried surgical and medical, I prefer oncology because patient need us for help and support.” (P1)

“I got my job training on oncology ward (411). And before that, also, I was very attached to oncology I did my research also (she meant graduation research for Bs regarding patient satisfaction). Since that time, I felt very attached, I wanted to spend more time with terminally ill patient with oncology patients.” (P3)

Besides, nurses’ participants were considered exceptional because they have shown attributes that make them exceptional through a thirst for knowledge, continual skill development, and personality.

So, research participants described the personal trait of oncology nurses as being loveable, empathic, owning affectionate, and being congruous, this disclosed by several participants who agreed with those points:

“Staff who work in oncology with cancer must be patient, loveable, tolerating hard situation.” (P1)

Moreover, one participant disclosed the need for owning a sense of humor as a complementary attribute for a nurse working with a terminally ill patient. Oncology nurses faced dying patient daily, which place them in a stressful situation. In addition, this sense of humor reminds patients that staff nurses are human beings with feelings and senses.

“And I think which is important, maybe someday will not agree that the news should have sense of humor.” (P2)

Having a good sense of humor also helps spread positivity to other nurses, patients, and their families, strengthening the bonds of expectations and trustworthiness between staff nurses, patients, and their families.

Other participants emphasized recruiting professionalism as an essential element of oncology nurse attributes, which leads to self-control, and enhancing emotional and mental stability while facing and providing care for terminally ill patients. As well, participants viewed professionalism primary condition to ensure nurses achieve the highest standards of care for their patients.

“To be honest, for the first few years dealing with the critical patient dealing with end-of-life patient and patient who are dying, it was very hard, especially if the patient we used to know used to talk with it was emotionally very hard to separate our own emotions from being professional.” (P15)

“I will give care for all my patient I like all my patient but they are my patient, and I cannot mix my social life or my outside work life with the patient. Like they will exchange their numbers with staff nurses me, they will get more involved, and they will get like a personal relationship and it will affect their work”. (P3)

Another aspect of professionalism the researcher conducted throughout the data analysis is respecting terminally ill patients’ decisions, fulfilling their desire, and protecting their rights and humanity.

“Dying patient need to be surround by his family, giving him last wishes, I remember one patient he want piano, nurse supervisor and family arrange matter and provide his with one, he was Very happy. ” (P11)

“Sometimes people in their last days will like to ask for specific things, for it we will do request from the kitchen or whatever to like bring this type

specifically for this patient. We want to fit in, we want them to feel comfortable even in their last days.” (P3)

Besides that, nurses’ educational background and perception of terminal illness affect the quality and safety of terminally ill patient care. The master’s degree holder participants defined well the terminally ill patients and explained their needs:

“They are at the end stage, most of them stage four, and there is no cure. They are.. they already received the first, second, third line of chemo, then they will shift the patient to palliative care [participants well defining terminally ill patient]. I wish to give them the best care to them. And I know that they will not live longer. So, from my side, I will try my best to give them the good care.” (P13).

“The terminally ill patients, for me, they are on two different types. The first type is the one that they are willing, they are normally that they are terminally and then they are they are having no other solutions. And the other type that they are not aware that they are terminally ill and they are critical in critical condition.” (P15)

“Terminally ill patient, we're the patient. Of course, first of all, you will be diagnosed, meaning you will get as a treatment when you make it the first-line treatment, second-line treatment, third-line treatment, where he will reach to a fire the treatment, which is not treating the disease, but relieving the signs and symptoms of the disease and keeping himself as much as comfortable from the signs and symptoms of the disease thing. Actually, we're sorry to say that till the end of his life.” (P7)

The bachelor's and diploma holders defined terminally ill patients as:

"Patient with total need for care and pain killer." (P1)

"Physical need... patient need physical need, to meet everyday activity need, giving baths, and feeding). (P4)

"Mainly patients need nursing care, support, pain killer, died peacefully." (P8)

Nurses' participants highlighted being exceptional not only through their knowledge and expertise to help their patients cope with illness but also exhibited a high competency level to provide psychological, emotional, and spiritual support, thus extending to patients' families and team members.

Besides that, this support is translated by various actions, such as emotional support deliberated through empathizing with suffering patients, calming scared patients, and giving them hope. Emotional care requires being compassionate, admitting and treating patients as unique individuals, speaking with patients' families, supporting them, and explaining the situation through open dialogue.

Additionally, spiritual support stated by participants through different statements ensures proper spiritual rituals tailored to fit each patient.

"Sometimes if the patient's willing we used to call for religious people like Shaikh Dean if the patient is Muslim and they're a Christian, the charge personnel will do pleasing." (P3)

"You have to show some compassion in the patient, you have to show some understanding, and you should know their situation". (P15)

“According to us, we want to leave them without any pain. And we want to give them a peaceful death. And we want their relative also to accept that this is what is going to happen..... So we will make them comfortable and they will we will give them all that social, spiritual or support psychological, social spiritual support we will provide.” (P4).

“And emotionally we are giving too much emotional support plus nursing care. Nursing.” (P11)

“A hope for his family [terminally ill patient] of course I will provide support, I will feel empathy with them if they are like they are young [young terminally ill patient], and they are ... they have no knowledge of their exact disease. (P3)

“Will give her then we will give her[patient] spiritual support side rather than psychological support spiritual support we will provide a Quran according to her religious customs we will let her to pray and let her to relax by talking to the guard like that we will help them spiritually and physically and mentally.” (P4)

The nurses' participants exhibited adherence to a job description, which is the scope of their practice that describes the services they were legislated for and permitted them to perform their competencies with terminally ill patients. So, it influences their behaviors, skill, attitude, and perception, abilities which affect the care outcome.

Nurse supervisor seems to have a tremendous task and role within oncology units, disclosed via different statements verbalized by the participant, as they considered the supervisor's roles to be coaching, providing a safe environment, binding a

cooperative nursing team, preserving a healthy work environment, and being supportive for the staff nurses in all circumstances.

“Our supervisors if you're facing any challenges, we will tell our supervisors, and there is a multidisciplinary team for deciding about the treatment I don't know. So, we never then counsellor I mean they all help us to meet the challenges. So, I never felt this is too difficult to face a situation.” (P4)

“Our supervisor very active, always helping us in our assignment, giving us psychological support, small educational session.” (P12)

“One nursing officer when he was coming, he saw me crying, he speak with me, he told me you cannot work like this if you will if you will cry on every patient you will ...you can't complete this profession his speech gave me like the emotional endurance I told myself I have to separate my emotion then from my work so.’ (P3)

On the one hand, the coaching by the participant for terminally ill patients and their families occurs in a different way. Participants seemed to innovate and evolve new nurses' roles in oncology clinical practice to meet terminally ill patients' needs.

Furthermore, participants showed trusted professional coaching skills, which help terminally ill patients overcome those challenges to establish treatment goals, modify lifestyle, and health conditions, and incorporate integrative physical, mental, emotional, and spiritual requirements to enhance patient adaptation to end-of-life conditions.

Thus, participants revealed through their words the role they have taken to coach and guide terminally ill patients:

“I instruct patient to read Holly of Quran or watch TV for Quran to be more spiritual. Also, I will help to bring water for prayer.” (P9)

“As a staff nurse, I have some responsibility to do give themselves support. And here we have one counsellor. She used to come here, and she will educate The patient as well as the family, and she will be psychological support and we will educate them, we will tell them about the diversion of therapists, occupational therapists, and about the diet and about the follow up about what things to be carried out what things to be done, and what vital things they should take care of while receiving chemo.” (P4)

“We will make them understand consent everything to be taken even the family members also called and explained from the patient and the family members we will take the consent and everything we will explain them so, ... doctors are explaining when during the chemotherapy whatever is there After the chemotherapy health education checklist.” (P4)

On the other hand, coaching principles adopted by participants include teaching other nurses and terminally ill patient family members, which empowers them to reach their goals. Moreover, coaching among the nursing team to enhance their knowledge and skills for best od nursing action delegated by physicians as disclosed by participants:

“I got chance for my training during consultation setting with doctor, I gain lots of knowledge.” (P2)

And other participants got a chance for coaching through a small lecture presentation.

“Only I received small lecture about chemotherapy, counselling, customer services.” (P7)

4.3.2.2 Intra and Interprofessional Communication:

The importance of communication is a fundamental element in diagnosis, treatment procedures, and care delivery for terminally ill patients. It is a pivotal element in preventing misunderstandings in communication between patients, their families, and nurses during clinical encounters, which are described as interprofessional communication, also, between the oncology nursing team members described as interprofessional.

Effective communication skills are essential characteristics of a nurse participant. Research participants considered their role relies on effectively communicating with other nurses, custody oncologist physicians, and multidiscipline teams across different units, patients, and their families.

Medical adverse events are more likely to occur without correctly interpreting and conveying communication perfectly, patients often feel neglected or misinformed, and the patient's relative will feel the impact. Participants describe this as miscommunication.

“doctors some time will not come to write orders or pain killer medicine, and sometimes they busy at emergency department, relative they think we did not contact doctor, and we are laying.” (P8).

By prioritizing and practicing tentative and professional communication skills, nurses will provide safer care and promote their patients' health conditions and satisfaction.

"I believe that the main thing that the nurse has characteristic she should be, or he should be carrying. Communicate Shen skill is very, very, very important. I think this is the key of each problem. Each obstacle of raising patient trust, trust building relationship. Communication is a cornerstone of in palliative care, beside the staff nurse she should be full of energy." (P16).

"Communications has a big role in providing care, something some patients they will... they will feel better if you will explain the procedure... Some patients they will say: no, I don't want you to explain like okay, proceed with the procedure. So I feel it's better to communicate with the patient." (P3).

"Communication within the nursing team it is okay because partner is there because we are a diverse, we are working together, and we are dealing with so many difficult situations and chemotherapy all this treatment more than we are going through. So, if any small mistakes small mistake does not mistake anything we will discuss small doubt we will discuss with each other, and if we couldn't solve the problem, we will ask for the doctors or otherwise other seniors and other words." (P4)

"There should be communication with all healthcare team, the consultant the nurse, the resident even the in charge with the relatives to set a realistic goal, should be set realistic okay, they should know our limits they should

know where we can stop what will happen, they should know all the all the possibilities and all the results if they are any.... if they have the chance to choose okay, we will let them to, but sometimes there are no options it's like.” (P3)

Research participants especially non-Bahraini participants uncovered facts about communication barriers and the struggle to conduct smooth communication with Arabic or Bahraini terminally ill patients. Participants considered this as a significant challenge that prevents them neither from providing essential patient needs or psychological needs.

“when I joint. I was not able to speak Arabic, amm I can’t understand Bahraini patients’ speech,, but know after eight years I can understand and speak little little word, and some Bahraini Baba [old age] they can speak same our language Hindi.” (P14).

“And of course, main problem for us the language barrier, you know, we cannot communicate properly because of the language we don't know Arabic very well, but we know whatever we need that we know some patient and nursing most of them knows English, if the patient doesn't know English, some of the relative may know English, we will talk to them. Otherwise, if the one who doesn't know Arabic, we will take help from the counsellor and also, we will take help from Arabic staff here.” (P4)

Bahraini participants verbalized the same issue regarding a miscommunication (language barrier) and justified it as:

“Language barriers for some type of patient, with different background even with the same language (she meant Arabic) ... sometimes we have

Arabic patient, but they are from different type (she meant from different country not Bahrain) ... totally different type of background.” (P3)

Respectfulness is crucial for nurse participants; respecting patients is a professional courtesy that must be extended to all, regardless of their attitude, response, and behaviors. Different and challenging personalities surround the care of terminally ill patients. Participants declare that respect between patients and nurses produced a transparent mode of communication, yet also between the nursing staff.

Moreover, nurse participants revealed that respect is the boundary that defines a therapeutic professional relationship, enabling them to deliver high-efficacy care for every patient.

“Being humble with patients, talking frankly, respecting patients’ desires, can make strong relationship with nurse, doctor, and patients...sometimes we became as family member.” (P4)

“We will know the patient has family even after patient expire and so they will communicate with us, and they will be in touch when they will see us they will be happy because we are if they are seeing us they will remember their patient.” (P11)

Terminally ill patients and their family members rely on nurse participants to be trustworthy and helpful; this is profound as integrity in nursing aligns with these expectations and requirements.

Possessing this quality of integrity adds professional values to participants, that ensure the consistent quality of care to all terminally ill patients while remaining

aligned with participants' ethics and professional priorities. So, its disclosed via different viewpoints of research participants.

“Doctors only allowed to explain patient’s condition and meet patients and their families to set a plan of care...our role is to carry out doctor order.”
(P10)

Moreover, patients who have established an open and secure dialogue with a nurse or healthcare provider were more likely to disclose the true extent of their symptoms.

“patient with chemotherapy can develop sexual dysfunction, so my patient [female] talk freely with me, and I explain the side effects of chemotherapy.” (P2)

“my role as counsellor allow me to talk with no boundaries with all patients, sometime at my office or patients side...involving family issues, financial problem.” (P5)

Besides that, participants revealed some remarks described as a limited–restricted conversation between terminally ill patients and nurse participants. So, this restricted conversation with those patients affected by their condition, medication, pain, and, or psychological status of patients. Also, nurses' and patients' cultural values and beliefs can lead to misinterpretation or reinterpretation of key conversations.

“Sometimes the patient themselves for their own cultural diversity, or whatever it is, they have a lot of restrictions of accepting the care from the healthcare provider, this might cause a conflict. Especially for the male and female in our culture. If you want to provide the supportive touch, even

if you were wearing the gloves, or this the patient themselves, they will not accept it.” (P15).

Through data analysis, the researcher found that nurse participants who take the time to listen and understand the concerns of their patients were prepared to address issues as they arise, resulting in better patient outcomes. This was found to be built upon a solid, respectful professional communication method utilised among them. Effective communication among healthcare providers is the key driver for the success of the healthcare system.

All the decisions related to patient care depend on effective communication among interprofessional communication. Communication and teamwork are the backbones of the oncology unit in SMC and help safeguard patients’ safety and health outcome.

In addition, communication between the nurse, patient, and family members involves more than disclosing information. It incorporates discussing various topics, inspiring them to share their feelings and fears about the nature of the illness, treatment options, and prognosis, and helping patients and family members find a sense of control and a search for meaning and life purpose. Nurse participants explained their strong communication skills with patients’ family members, which were shown to influence cancer terminally patients’ satisfaction positively, improved overall well-being, and enhanced patient experiences.

“very important to have a proper communication with clear word during handle over, and in our nursing notes.... Ammm this communication make treatment transfer to patient easy with good quality.” (P5)

“I believe in the charm of conversation with family not only patient, will make them comfortable and trusting us.” (P8)

Effective nurse-patient communication can improve the quality of care, clinical outcomes, and a nurse-patient relationship that enhances patient satisfaction. However, effective nurse-patient communication is the greatest challenge for research participants and requires more experience and skills.

“if I will explain the procedure and effect of medicine to patient, they feel happy and satisfied.” (P13).

The honest forms of nurse-patient communication include verbal and non-verbal communication (e.g., body language, facial expression, gestures, and distance between you and patients).

Participants disclosed various comments about the importance of body language, expressed via their words as mental attendance of nurses while treating the terminally ill patient, the importance of smiling, providing time for speaking, and body gestures can also send a silent message to patients.

“Because with the... aaam... you know, like smiling, we say in our religion that is [smile is gift]. Patients expect from the nurse at least to come with a smile. He doesn't want or he doesn't care if you have other 10 More patients or you have task he wants that smile than it should Enter for him with his mind.” (P₂)

“I remember once, a pregnant staff nurse, assigned on breast cancer patient, when she will enter room to give patient treatment she will put her hand on her tummy, patient feel irritated and shout on patient, I don't want to see this lady always always her hand on her tummy.” (P2)

4.3.2.3 Patients' characteristics

One of the most critical issues during data analysis is patients' characteristics and needs; terminal cancer stage is a significant health issue influencing the quality of their life. From the analyzed data, several factors were noticed through participants' verbatim speech.

Terminally ill patients' demographic characteristics seem to affect nurse participants emotionally and psychologically, contributing to the quality of end-of-life care.

Patient age does not form differences for some participants, as they disclosed that the care must be delivered, and tasks must be accomplished despite age. Their purpose of attending duty is to finalize their assignment.

"If we see young female patient with breast cancer, we will think about her kids, like empathy... One patient with small baby... she will put baby in her lab and want to give him a breast feed". (P4)

"Young they will think about their future, so they are not ready to die like that. So many experienced there, will not abuse us but our mind will be getting upset because of all these things." (P4)

Other participants viewed the care for young terminally ill patients as a significant burden on them, as they did not fulfil their wishes and life desire and lost their life, family, and beloved person.

"if young patient..we think he will leave life ...no pleasure... if old patients we know they suffering...but for young they did not live the pleasure of life." (P4)

“I remember one patient same my age...he is male...if I’m night duty he call me to speak with me for 2- 3 hours...after he dies I got shocked and not sleeping at night and thinking about him.” (P13)

Furthermore, some participants viewed old age terminally ill patients physically and mentally demanding, their mission was to control their symptoms and provide them with primary and holistic nursing care.

“old female demanding for each and everything, she want me to comb her hair, giving her bath even if her relative is there...old Haji [elderly patients] refusing to take medicine ..food... or even bath.” (13)

Moreover, participants disclosed that age can affect the quality of care delivered by nurse participants and that gender appears to make distinctions. Some participants revealed that young female terminally ill patients face death daily and are expected to lose their life, kids, and family at any time, which causes distress for female participants, as they imagine themselves in their shoes, and became overwhelmed by thinking about who will care for patients’ kids.

“I assigned for female lady...she is calling me to give her bath and dress well.. and but perfume..[she said: my sons and daughters will come during visiting hours..I do not want them to see me weak and sick].” (P13)

sometimes female patients are more demanding but we can accept that the fact because woman they face the demanding community especially their ladies, [.....]Maybe she faced a lot of things she took care of a lot of children so maybe she feel exhausted.” (P3)

“Elderly female terminally ill they are more demanding they will be nagging more and grumbling more... that is sometimes because when you

want to provide the best care ... like you want to start IV, but patient is nagging especially for unrelated things that affecting the quality of care provided.” (P3)

Also, female participants declared that male care is restricted by religious boundaries and patients’ religious backgrounds. So, Muslim male terminally ill patients refuse Bahraini Muslim female participants to provide them with primary care, bathing, feeding, perianal care, and changing positions but show acceptance to receive similar care services from female non-Bahraini staff nurses.

“female patient we can touch their hands.. give them hugs.. sit close near them.. but in our Islamic religious forbidden to do that for male patients.” (P7)

Regarding the religious background of patients, female participants disclosed that supportive touch or hugs can’t be provided for Muslim terminally ill patients, and professional conversation must be implemented. However, non-Muslim terminally ill patients accepting for spiritual, and psychological support.

“There is barrier between female and male. And this is what I think the difficulties in our work because we don't have a male patient even mean they will not feel from our culture and the community. They will not express their feeling for anybody, maybe if he is elderly, he will express, like, I'm his daughter will not feel bad, okay, but if he's young, he will not get comfortable to, for example, express his sadness or his emotion. This is very difficult even in our culture, not only a patient in our culture men very difficult to express that feeling okay, for female patients.” (P12).

The patient's cultural background also influenced the quality of care provided by nurse participants, as disclosed by the participant in a case she treated, and a Hindu patient in a terminal stage who refused a blood transfusion as this ritual is against his cultural beliefs and customs.

"Cultural also religious like for some type of religious or some kind of religious they will not accept blood transfusion. So, how we will shouldn't go. [Hindu].. How even convince them that this is wrong and life-saving for them some people they will not accept the fact." (P3)

In addition to demographic factors, it was noticed that socioeconomic burden caused distress for terminally ill patients, as some of them are non-Bahraini, and their financial status is very low. They cannot offer money to cover treatment expenses. Hence, participants feel hopeless as they cannot offer proper treatment.

"We faced on Philippine old lady, doctor decided for chemotherapy... but she is poor, can't offer money to cover treatment expenses". (P4)

"Financially if the family is financially well settled, they will be more comfortable if financially not settled. Because they think about their family future, think about the future they can at least to my family settled Well, I don't have to worry about them." (P4)

Moreover, some terminally ill patients will be worried that after their prolonged admission and death, they will lose their job, and their families will face a financial disaster, which places a participant in disappointment because they cannot offer help to those patients and their families.

“patient was sitting alone, not sharing words or speaking with us...his is early 40th with metastasis colorectal tumor..sad and thinking if he die who will give money to his family.” (P10)

Another aspect of the socioeconomic burden participant verbalised and affect the quality of care provided for terminally ill patients is that patient have issues and worries about inheritance and guardianship. Some relatives will have family and legal issues regarding this matter. After seeing this legal issue, most participants were affected by losing trust in their family members and the people surrounding them.

“I saw some some like some relatives, they will come when the patient is sedated and they will take his finger stamp and sometimes when the patient is confused, was little bit confused because of the treatment and the son he came and said I want to take my father out on bus [official permission to go out of hospital] for a few hours. Okay. Then, the next day, we hear from the father Himself my son he took me to the court to to give him a custody for all his wealth after father expiration.” (P3)

On the other hand, participants correlated the behavioral changes in terminally ill patients with the changes in their health status.

“patient will kick us, beat us while giving him bathe, this is maybe because of pain or disease.. we don't know.” (P1)

“We can understand patient and family angers... we will listen to them.” (P4)

“Old age patients they will tell us bad word when we change their diapers or giving them bed bath.” (P6)

“I remember that patient he maybe in his late 40s or early 50s [walking patients]. He will specifically find that time of the shift is only for females of only female stuff. He will ask the Indian staff exactly Can I book for bath [he means to be given bath by staff nurse]? Like we are in a hotel or a spa? Can I book a bath for tonight?” (P3)

Furthermore, research participants declared that some terminally ill patients made their minds with wrong decisions, which is against the doctor’s treatment plan, thus, that affects participants negatively and contributes to a decrease in the quality of care delivered. Hence, to refuse the treatments in some cases, e.g., palliative chemotherapy, oral medication, feeding, etc.

“Some patient are not accepting the medications. They will not take any medication. They're telling if taking medication. If taking or not taking I will die then what is the use of this medication.” (P4)

“Some patients doctor will explain full treatment plan in clinic, but patient will refuse treatment and will miss their follow up in the clinic.” (P6)

“I serve a breakfast meal, old mam getting angry, and refusing for food... because she used to be feed by her daughter in law.” (P12)

Moreover, behavioral changes may occur because of disease progression and its complications. Patient attitude and behavior as part of a terminally ill patient personality could affect nurse participants negatively or positively. Participants viewed cancer disease as leading patients to behave as its social stigma and isolating themselves from society or causing a disturbance in body image, especially for females with breast cancer. Some participants revealed that

terminally ill patients consider the disease infectious and will avoid contact with their families.

“one female patient admitted with breast cancer, she refuse to sit with her family, husband, or even other patient in the same room, she was feeling loss of breast like stigma as she lost her breast and beauty.” (P4)

Also, participants pinpointed patients’ level of education, their awareness of disease condition, and their suffering from a complication of the terminal stage, all factors play a vital role in the type and level of care delivered by nurse participants.

Qualitative findings revealed that educated patients understand the nature of the disease and accept the treatment modalities and alternatives, which help nurses tailor a care plan to fit their needs and fulfil their wishes.

“So, the most educated and the most understandable person, we will educate them, and we will consider choosing one of the family member as a caregiver, according to the patient.” (P4)

“Educated patients will argue to much about disease and treatment and will ask a lot of question.” (P10)

“I remember one staff nurse...diagnosed with ovary cancer... actually she was a nurse supervisor...she is educated and knows her prognosis...but she was refusing and neglecting our care and advice.” (P13)

Data that emerged from interviews indicated that patients with low education levels or illiterate patients could not understand the purpose of the treatment plan,

which leads to nonadherence, subsequently interfering with the care given by a nurse.

“Educated patients, they are accepting they know whatever doctor says planning they know but if not uneducated patients, they are not getting that much knowledge. Even we are telling them cancer also doctor is explaining or so they're not getting that much knowledge.” (P8)

“There was one old lady... her sister-in-law come to detect her breast mass ... big mass by sudden ... she took her to emergency and admitted in our ward... she was completely not oriented about her condition... accepting to take medicine... but she passes away fast.” (P15).

One of the essential points discussed by participants in the medical history of a terminally ill patient. Some patients presented with different comorbidity causes such as hypertension, cardiovascular disease, diabetes, mental disorder, etc. And some diseases occur due to cancer end-stage progression that affects the body systems. Thus, that nurse became disabled to overcount the multi-organ dysfunction and in some circumstances failed to design a care plan.

“Our patients will not come only like cancer. They are diabetic hypertension, cardiac, they have so many issues... other psychiatric, the medication we are giving all this effect. [...] The patient sometimes we have patient with Alzheimer's, and we faced a lot of problems with this type of patients are sometimes schizophrenic patient, they will like they will call the nurse supervisor and they will tell that someone takes their belongings or eats their food as well [they meant staff nurses]. (P3)

“Most cancer patient presenting here with different previous history which make complication of cancer worse.” (P1)

“Chemotherapy may cause cardiac toxicity, or maybe neuropathy, but what makes scenario worse they already have cardiac failure and diabetic neuropathy.” (5)

4.3.3 Moral Distress

The third main core theme that emerged from data analysis was moral distress. According to the research participants and as described by Soleiman et al. (2019) distress is a psychological discomfort that occurs when a person cannot complete what they believe to be an ethically responsible action due to internal or external factors. Based on this definition, nurses may have professional work requirements that conflict with their morals and belief. According to the sum of data, emotions, feelings, and expressions obtained by researchers from participants, moral distress is appropriate for their experience.

This theme included three axial sub-themes to discuss the dimensions of moral distress experienced by nurse participants.

4.3.3.1 Inadequate Quality of Care

Inadequate quality of care dismissed by SMC health institute, oncology units, and nurse participants negatively impacted nurse participants, placing them in a conflict between proper ethical practice and low patient health outcomes.

Nurse participants emphasized that important aspects could cause them moral distress. This is about needing more experience in working with terminally ill patients. From their point of view, a nurse who is supposed to work in the palliative

unit or face a dying patient must possess skills and competencies to enable them to handle such a case. Because those cases seek not only physical care, but also need psychological, emotional, and spiritual support. However, the nurses recruited within those units for terminally ill patients must be prepared to face them.

“I worked four years with oncology patient..I did not receive any training,,, only small lectures...So it's better to have training before joining so if somebody is recruiting the staff knows when the oncology unit is better to have training before that ..”(P14).

“I just received some type of lectures from counsellor and or any other senior colleagues and the experience I got from working with doctors, but I wish I could get the chance to study something official for terminally ill oncology patients.” (P3)

“I think all of us [nursing team] need to go for courses or small studies for to improve our professional professionalism with patient and with the relative, the way we speak it different a different maybe we will speak it just like that but to really stay and patient or political mind forever.” (P3)

Several participants commented that the need for educational and training programs before joining the oncology units and even after joining the units causes serious complications and obstacles. Those obstacles translated through the comments of participants, who described their experience without training or education sessions for sensitive cases as a “hard experience”, and a difficult time and they believed in lack of training program will provide nurses with the poor skills to reach their full potential in maximizing patient outcome.

“I do believe that providing a program that helps the staff themselves to understand the end-of-life care and how to provide the end-of-life care could improve the care and the quality of the patient life dramatically. It could change it 180 degree but it's not provided.” (P15)

“I didn't even receive the study for chemotherapy that training that three month or six-month training with a certificate. I'm not sure why it won't happen.” (P3)

“chemotherapy teaching program... because this is new field for us we were medical, and we are totally introduced to the new field. So, we will know how to calculate we did not know how to calculate the BSA, how to calculate the tracks how to give chemo while giving chemo at all things to be noticed. All these things were not given to us.” (P4)

Moreover, a participant expressed their lack of knowledge about the cancer terminal stage, its concept, and the required care, which subsequently affect the quality of care.

Misconceptions about terminally ill patients, cancer terminal stage, treatment modalities, and nurses' practice during this phase that reported through:

“ammm... patients who needs a total nursing care.. feeding.. changing position, and attending for chemotherapy.” (P1)

“I can see them like any type of patient, I feel I can see the time limit for them. So, I want to provide the best for them before my time finish, because I don't know when we will go. No can know for this type of patient, I feel that time limit time is very important. I don't want to waste any time with without giving care... Yes. And I want them to enjoy or to benefit from their

time to the maximum I want to see them with their family more because in any time, they may go, I want ... a I prefer if they have commitment to finish it or they have limited time to finish. (P3)

Participants claimed the importance of employing and running a successful training and educational program and activating a palliative training and education program.

Participants disclosed the issue of being stressed and overwhelmed due to the continuous nurse workforce shortage in oncology units. This shortage cannot cover the needs of terminally ill patients, correspondingly increasing the exertion on participants and decreasing the quality of care they provide, which is quoted from several participants:

“Actually, the most important thing is the workload it can affect the performance of the staff. Okay... only three staffs per sheet. So it's a burden for us. Because sometimes we cannot be with one patient all the time., because each staff is getting six patients assignment, of course, will be very busy sometimes terminally ill patients, dying patients, there will be ventilator patients so hard to use. And so our spending time with the patients each patient it will be reduced”. (P8)

“I remember that brother of the patient, he came and for our supervisor to complain about me saying: where she [staff nurses] is not staying all the time near my brother [terminally ill patient], Okay, I told him [patient’s brother] all my patients are cancer cases, I have five patients. I cannot provide this type of care only to your brother...leaving other patients and staying near to your brother.” (P3)

“It will affect the quality of care that we are giving. It's not like if we are like staff nurse to patient ratio 1: 23 we are 1:2 or 1:7 each shift.” (P3)

“Sometimes you will call the doctor he will be delaying delaying especially on call. So, of course, this one effect the quality of the quality of care for the patient, patient will start to fade out he will show problems will have been conflict because of time management or because of lack of professionalism.” (P3)

Furthermore, some participants declared their frustration a “lack of choice”. There was no other choice than to be recruited into the oncology department, they did not get a chance to choose their area of interest.

Also, participants viewed this frustration, as a leading cause of recruited nurses that are not competent to provide terminally ill patients with a valuable base of support in their fight and disease progression.

“Factors that affected my choice but not to drive me through into it. The things that made me being hesitant to work in oncology of what terminally ill patient or with oncology patient overrode that my father is actually an oncology patient. So I was not preferring to work in the area that he was accompanied. At the other hand, I had one of family members who already expired recently from oncology.” (P15)

“First of all, the ministry, they sent us according to the vacancies to the wards. So, it wasn't my first choice. But when I joined the oncology Ward is essentially that the VIP ward, I found it a bit challenging to deal with end-stage cancer patients.: (P7)

“Actually, we didn't choose to work on oncology. Actually, I want to work because under a critical care area, which is my choice is a critical care area. So I was there, and they turned here since that time.” (P12)

“really when I joined in 2015 as oncology nurse, I was very upset because we are totally introduced to the new field. That means we will have to give chemo chemotherapy. It was totally new for us [nursing team], and we have to see for all extravasation, and it was too much risky for us first starting.” (P4)

The researcher noticed while analyzing data, that the differences in oncology care settings for terminally ill patients limited the nurse’s ability to provide proper care, communication, and support.

Some participants declared that working in an outpatient setting allows nurses to provide limited services, e.g., palliative chemotherapy, and follow-up consultation with physicians. That means a restricted opportunity for communication, psychological, emotional, and even spiritual support.

“outpatient clinic offer chance to make a small community, because we receive the same patient frequently...we give chance for counselling session, dietitian visit also... we celebrate special function like breast cancer day Etc.,” (P6)

Some participants viewed the inpatient setting as an excellent opportunity to gain knowledge from different cases, skills, and procedures that enrich their experience, reported as:

“I worked in ward 4.. for three years, I left inpatient care unit because of my health condition, I came to clinic ...I like work at ward ...seeing different

case and giving a full treatment plan...I have chance to talk to patients...but after I shift to clinic.. here situation different.. no enough time to talk to patients or to know their families as short visit.” (P3)

“We are very busy [inpatient ward], we were that time when receiving palliative care. Only palliative care only palliative care means there is no game only bedridden self-care at that time. We were a little bit it was very tough for us because we are only three staff and 20 patients in out of 20 Round 15 patients bedridden. So, we faced a lot by then when chemo started it was okay all patient most of the patient walking and the way we had hardly I think five or six patients at that time as bedridden, but again tension from chemo complications.” (P4)

Participants’ comments reflected the health institute’s effort to bond this gap through small lectures, and training for chemotherapy installation. But still not enough to overcome participants’ competencies.

Besides that, participants stressed the urgency to initiate educational and training programs and emphasized the role of community awareness regarding terminally ill patients’ suffering, needs, and required care. Participants disclosed that community awareness provides the need for continued supportive care for those patients and their families.

“still our culture with think about cancer as a death sentences, .. this is this is wrong .. we need to give awareness and correct information about disease and how to help cancer patients.” (P5)

“So no need to be socially and get away from the society, you will have to participate in or on social activities. The for this mean in in the family and

social support first education the more educated, the more aware about the situation they can accept it what is going to happen and there will be willpower. If they have willpower. According to my experience, if they have willpower, the recovery will be soon.” (P4)

4.3.3.2 Family caregiver role

Participants declared that family members, close friends, and relatives can take the role of support for terminally ill patients. Providing support can enhance patients' health conditions leading to the best outcomes.

“And the first situation will be more relief for us like they want to the patient as soon as he will be discharged they will sit the house with everything he need they will take like oxygen they will take the bed they will buy bed.” (P3)

“Most thing that maybe I face, that husband is near to the wife, and she is end of life. And she's calling, calling me from outside to hug her. I felt shock and very bad, because he's 24 hours with her but never giving her a hug.” (P12)

“Mainly here is my experience from here all the family members are very supportive here for them. If family or husbands or wives they are supporting each other from my experience here, so if they want to somebody close relative will come and stay with her onwards, there is there was special permission that time.” (P4)

Nurse participants revealed that if the relative is confined in the denying stage, not accepting the reality of the patient's health condition, the nature of disease

progression and the needs of this stage produced a burden and moral distress on them founded in their quotes:

“Sometimes if the patient is very young, sometimes their family they will fight more for them. But they will fight sometimes some unrealistic things they wanted to be happening they want miracles to be happening, but miracles are not happening.” (P3)

“too much socially social problems we faced during this period from the family, although it is explained to them by the doctors, but they are not ready to accept the acceptance is not denied is one of the stages of death.” (P4)

Participants disclosed their distress when a relative hide the truth and facts about the disease condition. This places them in narrow angles because doctors suspect relatives of sharing information with patients. Still, relatives hide that information, and nurses will be facing this situation and mandated to disclose that information, and apparently, this causes a heavy burden on participants.

“there was a patient with prostate cancer...admitted for chemotherapy..his son stressing on us, please do not tell my father you will give him chemotherapy or he has cancer.” (P1)

Nurse participants stated their feeling of upset and moral conflict from family or relative attitudes when they violated a patient’s right to decide. They will take this right forcefully. And some consider terminally ill patients lost their ability to decide on treatment plans and options available.

“Family Members.. I saw some men because he's a man. He's next of kin he has the right to take decision instead of his wife or his daughter. (P3)

“The palliative doctors... when they come, and they will write the medications for pain relief, But sometimes we are not able to give that medications. If patient is in pain, also, we are not able to give them medications because some relatives, they will tell she's sleeping always don't give her medications).” (P4)

“I remember a young lady she was a mother, our colleague, she came with her for the consultation. She [the patient] was already stage four, doctor decided a treatment plan... her daughter [patient's daughter] refuse treatment and tell her mother they will travel to Philippine for better management....after few months her mother expired because of the daughter decision. (P3)

Participants expressed that terminally ill patients' relatives' and families' dissatisfaction makes them feel disappointed, and their work effort not appreciated. But anyway, they are obligated to work and face this dissatisfaction, which hurts their pride and humanity's core.

“Sister... we don't need gifts from patients... at least to say thank you... be good and polite with us...shouting on me cause me to be depress.” (9)

“But sometimes patients and their families they will think we are neglecting them, especially if we're busy and rush to do work.” (P3)

Another burden shared by the participant was the blaming attitude of relatives. Participants disclosed that their pride, humanity, and well-being were affected when relatives or family members added up the blame and responsibilities of the disease progression on the nurses.

“There is a patients admitted for observation...she was fine talking with her husband and 3 sons..after visiting hours family left unit...we call them after 30 minutes patient collapse... her husband became panic.. shouting on us.. blaming us..[you kill my wife].” (P7).

“They're blaming us because they are not accepting, they cannot accept because small children and this young lady [young terminally ill patient] dying even they are old also family cannot accept it, they are the nearest closest relatives, they will not accept. So, like that so many problems we faced a while ago, one day they were related destroyed our computer and computer telemetry.” (P4)

4.3.3.3 Management ethical issues

Adherence to a health agency policy is obligated for staff nurses, and participants declared that adherence to hospital policies causes severe moral distress and conflict within themselves or the team.

Many dialogues from many participants occur to clarify how hospital policy sometimes restricts their decision and the care delivered to the patient.

Some participants believed that a terminally ill cancer patient with lungs and bone metastasis dying and gasping and their right to die peacefully without resuscitation or chest compression or even endotracheal intubation and or mechanically ventilated. But hospital policy advises carrying out cardiopulmonary resuscitation for all collapsed patients without exceptions. So, the participant disagrees with this policy. Still, they cannot object as it is a hospital policy, and they are obligated and mandated to respect the hospital's role and regulations.

I mean, I told you regarding CPR (cardiopulmonary resuscitation) and all these things. So they are, aaaa, like for us, we don't have like DNR (do not resuscitate) in our hospital, we don't still we don't have DNR, but if they want, they have to provide for them, especially for this this categories (terminally ill patients). Some of them I mean, I told you about that guy (son of the terminally ill patients). He said, Don't call CPR for my father because it's his life, if he said be an offer my father, but I don't have anything officially. So, me as a nurse, I will be questioned in case if I will not call CPR. Within same time they have some wishes like the Son he said, Don't go for CPR. But me as a nurse because of the hospital policy, I have to call the CPR.” (P13).

Another issue about a hospital policy presented in disclosing information to patients. SMC Hospital policy prevents staff nurses from disclosing some information to patient or their relatives. The information must be delivered via a custody physician. This places nurse participants in a situation that can affect communication and trust between all parties. And some patients and their relatives will lose their professional relationships.

“There is many restrictions, you can for example, you as a nurse, you are taught to, to have some restriction, you cannot give more information about the progression of the disease, even though you know, that the patient reached to a terminal stage, okay. Even you a few patients will ask you about, tell me a little bit about my condition, okay? You will say that I cannot say anything (staff nurses), your doctor will say, this is one restriction, second things that you are you're also, job, okay. And your job

description, okay. And their policies in here in the hospital will not allow you to give more exploration about the disease to the vision.” (P5)

“So we should obey the policies and procedures of that particular hospital and how they are dealing how according to their policy, how they are revealing bad news or Breaking Bad News into the patient and relate this here. Fortunately, doctors are disclosing all the things, and sometimes they will ask the ladies to go to the clinic, and they will explain from there. But we know this already we will ask the related to go there, and the clinic and the doctor will explain you so when we come when the relators come back to us, it's very difficult to face them because then some of them will come and ask us, sister, nothing can be done.” (P4)

“We are calling CPR, some doctors will say verbally No need only gentle CPR when the anesthetist, they're coming for intubation, that there is no word of general CPR there is nothing like that gentle CPR. So, even the relatives will refuse for them integration, but the doctors are insisting to do integration. So, there was too much conflict between when that anesthetist come they will shout us why you called this is palliative care why you called for integration is there they have written then we will do gentle, gentle CPR.” (P4)

Moreover, the lack of some resources such as chemotherapy agents or medication makes patients blame staff nurses and relay the delay in receiving a cycle of chemotherapy to nurse participants, which will not consider this issue as a hospital management matter.

“Delay of the medicines I mean some medicine sometimes out of stock if for example was chemo six cycles seven cycle total cycle in between the medicine without a stop patient would feel very bad.” (P9).

“Many times, we face that this patient is coming in 15 days in the role there is some chemotherapy cycle 14 days, they will come for the next cycle the medicine is out of stock like that too much. So, the treatment will be delayed, and there is a progression of disease again. So, this is the most difficult thing I faced here.” (P4)

4.4 Chapter Summary

This chapter has summarized the findings of semi-structured interviews following Braun and Clarke (2006). The analyzed data classifies into three main categories (themes); the first discussed exhausting versus rewarding experienced feelings. These included two subthemes, positive emotions and negative feelings. The second explained factors influencing Nursing care, which included three sub-categories, nurse characteristics, Intra and Interprofessional Communication, and patient characteristics. The last theme derived explaining moral distress experienced by nurse participants, which contained three sub-categories, inadequate Quality of care, family caregiver role, and management of ethical issues. The study findings facilitated the exploration of oncology nurses' emotions, feelings, and experiences with terminally ill patients in oncology units in Bahrain, helping them understand their perception and the quality of care provided. Moreover, findings enhance the researcher to construct recommendations that promise to improve the education and training for oncology nurses and help them to get counselling sessions.

The next chapter discusses the qualitative findings to compare and contrast them with a literature review to understand oncology nurses' experience from a different view of points.

Chapter V

Discussion

CHAPTER FIVE: DISCUSSION

Discussion for this research was held respectively to compare and contrast the nurses' experiences with terminally ill patients in Salmaniya Medical Complex with current literature and to find the similarities and disparities in the experience.

Three main categories emerged from the data analysis. The first theme that will be discussed is “exhausting versus rewarding experienced feelings”. These included two subthemes, positive feelings and negative feelings. The second explained “factors influencing Nursing care”, which included three sub-categories, nurse characteristics, Intra and Interprofessional Communication, and patient characteristics. The last theme derived is explaining “moral distress” experienced by nurse participants, which contained three sub-categories, inadequate quality of care, family caregiver role, and management of ethical issues.

5.1 Exhausting Versus Rewarding Experienced Feelings

The present study findings illustrated that nurse working with terminally ill patients experienced emotional challenges from their prolonged and daily exposure to suffering and death. Moreover, the nurses were emotionally challenged by describing their experience of being rewarded and positive feelings or exhausted and negative feelings, this aligned with de Carvalho Alencar et al. (2017) mirrored the nurses' feelings towards the terminal cancer patient during the confrontation routine work mandated an emotional involvement which described positive feelings related to the nurses' motivated and enhanced performance for the patient with cancer under palliative, and negative feelings of impotence and frustration influencing terminal care

management. Besides that, Raingrube (2015) reflected oncology nurses' positive feelings and motivation to continue working with terminal cancer patients because working experience taught them to be better people, thankful, constantly learn from the practice, value the moments, and recognize life's priorities. Negative feelings/ exhausted feelings revealed in this study were expressed through anxiety, compassionated fatigue, and dissatisfaction. Bekelman et al. (2016) agreed with this finding and highlighted that the suffering and death of a cancer patient could bring up many anxieties for oncology staff and lead to developing emotional labor and compassion fatigue which subsequently impacted the quality of delivered care. Beck (2011) emphasized that compassion fatigue was present in 25% of medical nurses and 78% of palliative care nurses.

Professional dissatisfaction emerged from several factors, such as the increased number of cancer patients who died during admission to the ward, the gloomy nature of the oncology care environment, and the feeling of incapacitation to help cancer patients and their families (Banerjee et al., 2016). Furthermore, the negative emotions highlighted the negative impact of the terminal cancer stage on participants by perceiving any physical pain as cancer which is consistent with Cal & Aydin's (2018) findings, who claimed that nurses who work in the oncology unit correlate the intuitive sense of pain with malignancy, this negative psychological response is prevalent among nurses who care for cancer patients and the majority of the nurses in cancer care had experienced cancer fears during clinical practice (Faria & Maia, 2007).

5.2 Factors Influencing Nursing Care

Research participants professionally encountered terminally ill patients with several challengeable factors that affected the quality of End-of-Life care

provided. Those factors peered with the participants' demographic data, such as gender, educational background, year of experience, marital status, and age. Hurteau et al. (2019) emphasized that healthcare agencies and academic institutions provide valuable insights into how certain nurses' demographics (age, gender, nursing experience, and others) influence nurses' attitudes toward caring for dead and cancer-dying patients, the older registered nurses with more experience tended to have more positive attitudes toward death and cancer-dying patients. Participants' years of experience play a vital role in managing patients' physical and mental conditions, maintaining emotional stability, and proper therapeutic communication. Brajtman et al. (2007) illustrated that experienced oncologist nurses who adequately prepare for the oncology setting exhibited a positive attitude towards the profession and used effective stress management skills to enhance the quality of nursing care. Conversely, Benner (1984) developed a theory from novice to expert that illustrated the excellence and power in clinical nursing practice and viewed that several years on the job in the same or similar situations might create competence; however, the passage of time and the occurrence of events and interactions does not automatically confer expert status.

Participants reported that the highest nursing education degree as a Bachelor of Science in Nursing (BSN) or Master of Science in Nursing (MSN) degree correlated with high knowledge and skills. Therefore, the MSN holder participants only showed a broad, rich knowledge and perception of cancer terminally ill stage hence increasing the quality of care provided. In line with this finding, Dias et al. (2017) revealed that oncology nurses with a higher education degree revealed higher scores for remuneration and achievements factors compared to those without higher education; those with a BSN degree and secondary education had higher levels for the remuneration factor than

those with or without elementary education. In contrast, Rahman & Don. (2015) showed no significant association between nurses' higher education level and quality of care and patient safety.

In addition, research findings represented that job satisfaction influenced the experience of the participants and the oncology team and the professional practices at oncology units. For instance, several factors such as autonomy, salary, interactions among teams, task requirements, organizational policies, and professional status were studied by Silva et al. (2017) and showed that autonomy was attributed to job satisfaction among oncologist nurses.

Mojarad et al. (2019) emphasized that nurses' professional growth is associated with providing high-quality nursing services. Patients' recovery means observing nursing performance standards that are obvious in nurses' responses to patients' questions, accountability, task orientation, and work ethic. Qualitative findings reflected that some participant's obligate professionalism as an essential oncology nurse character which influenced experience with terminally ill patients toward safe morals, practice, and relationships with patients and the health care team.

Research findings identified the participants' role in providing physical, psychological, and spiritual support factors influencing participants' experiences. Haavisto et al. (2021) also mentioned this result similarly, who revealed that oncologist nurses described the competence required for end-of-life care as physical support and an organized environment rather than offering mental or spiritual support. Conversely, Iani et al. (2020) showed that psychological symptoms are controlled through individualized, narrative psychotherapy to reduce psychosocial and existential distress and promote dignity, meaning, and hope in end-of-life cancer patients. In line with these

findings, Balboni et al. (2013) revealed that religious community spiritual support is the medical team's provision of spiritual support and end-of-life care. Terminally ill patients receiving high levels of spiritual support from religious communities are less likely to receive hospice care and aggressive medical interventions at end-of-life.

Terminally ill patients possess factors and characteristics that can influence participants' experiences; these research findings reflected that young age terminally ill patients made them more empathic about losing their life without fulfilling their wishes. A study conducted by Grech et al. (2018) explored nurses' experiences in providing End-of-Life (EoL) care to patients with hematologic malignancies. The study revealed that providing nursing care at the EoL was perceived to be particularly challenging with younger patients or their family members. Regarding elderly terminally ill patients,' nurses' participants faced difficulty convincing them to take medication, accept some procedures, and understand the disease process and its complication. Consistent with this result, Suhag et al. (2015) investigated the same issue about elderly terminally ill patients and recommended education for healthcare providers and nurses to eliminate cancer patient age bias and achieve optimal care for older patients.

Kautzky-Willer (2014) mirrored that gender sensitivity has become a fundamental goal in preference-based medicine and cancer patient care, consistent with this study. Ullrich et al. (2019) suggested that a patient's gender is perceived to affect coping responses to physical and psychological burdens during palliative care. Female patients were described as using more expressive strategies to respond to their illness, such as sharing feelings and having more abilities to acknowledge their situation. Also, neglecting gender differences might prevent patients from finding their subjective way of coping with their

illnesses. This research's findings which showed the impact of terminally ill patients' gender on research participants' experience, it seemed female patients are more demanding and seek more attention and care rather than males, and this restricted the quality of emotional and psychological support provided by female staff to male patients and vice versa in obedience to religious and cultural boundaries. Previous studies finding were in line with findings.

Besides the gender and age of terminally ill patients, other interesting findings affected the experience of research participants, which were symptoms and suffering of terminally ill patients, such as physical and psychological pain and physical symptoms till the shutdown of most body organs, These findings were consistent with the findings of Clark (2017) declared that expert nurses' must be recruited for terminally ill patients to reassure them they will reliably receive expert end-of-life care to minimize distressing physical suffering and symptoms.

Participants in this study found themselves restricted by the terminally ill patient religious and social background, Castaneda & Scanlan, 2014; Karatay et al., 2016) found similar findings in their study; Asian Americans, African Americans, Latinos, and Muslims cancer patients reported that the quality of their care was diminished because of their ethnicity or race. Similarly, Periyakoil et al. (2016) revealed that cultural beliefs and practices are particularly significant in cancer patients' experiences of suffering. Yet, palliative nurses often poorly understand them, mainly when their backgrounds differ from their patients.

Jansen et al. (2018) expressed those patients with high educational levels and/or solid social support have a more favorable outcome than patients with low academic levels. Also, socioeconomic status is reflected in doctors' try to meet

highly educated patients' requests. This results in the overtreatment of the highly educated, while patients with lower education would receive standard or possibly substandard treatment modified from clinical guidelines. This aligned with research findings and emphasized participant experience impacted by educated terminally ill patients to receive precise treatment and care with well-defined objectives, rather than those uneducated or with a lower educational level.

Interestingly, interprofessional and interprofessional communication factors influenced nursing care for terminally ill patients. Research participants emphasized communication skills and their importance in building professional and trustful relationships with the nursing team, cancer patients, and their families. Successful communication is described as effective communication. Meanwhile, miscommunication was explained as a language barrier, misunderstanding of body language, and limited-restricted conversation. Aligning with those findings, Clark (2017) emphasized that nurses need to focus on the current situation, listen carefully to the patient, and observe gestures and expressions instead of just performing caring procedures. Marlane & Booth (2020) conclude that the importance of communication with terminally ill cancer patients has shown an extreme need for open-honest communication, involvement in decisions about their care, and close monitoring with a regular assessment to allow them to cope with the instability of their condition. Mojarad et al. (2019) conducted a study aimed at examining nurse experience in bedside care for terminally ill patients, and findings indicated that nurses communicate with patients by showing a willingness to communicate, such as being happy, making eye contact, smiling, introducing themselves to patients, and touching their hands and backs because they followed to build trust to be able to fulfil patients' needs, this consistent with

research findings about the significance of body language as a communication skill.

Qualitative research findings highlighted poor communication, so this is consistent with the qualitative interpretive study conducted by Thorne et al. (2013) aimed to understand helpful and unhelpful communication from the cancer patient perspective across their cancer journey; the results disclosed that patient accounts reveal three types of poor communication; “Ordinary misses” are everyday missteps for which maturation and socialization may be adequate solutions, “Systemic misunderstandings” are assumptive gaps between patients and professionals, and “Repeat offenders” are a subset of clinicians whose communication patterns become a particular source of patient distress. Miscommunication extended to be described by non-Bahraini participants as “communication barriers”, and Wazqar (2018) agreed with this finding and revealed that language barriers were frequently cited as work-related stressors of some participants, so they found in their study that some participants expressed great difficulty in communicating with people with cancer in some situations due to language barriers.

5.3 Moral Distress

The research findings revealed that nurse participants experienced moral distress in response to different causative factors described in research findings as three sub-categories: inadequate quality of care, family role as caregivers, and management of ethical issues. Inadequate quality of care was uncovered in the research findings. The oncology care setting (inpatient/outpatient) affected participant quality of care delivered, creating a gap, or limiting the nurse’s ability to provide proper care, communication, and support. Aligning with this finding, Suhonen et al. (2018) conclude that nurses prioritized patient care or

participated in the decision-making at the bedside and in the oncology unit. Bedside priority setting, the primary concern of nurses, focuses on patients' daily care needs, prioritizing work by essential tasks, and participating in priority setting for patients' access to care. Also, misunderstanding reflected during cancer terminal stage care arose from community misconception about the terminal stage leading to inadequate quality of care delivered by nurses, McCabe et al. (2010) explained that cancer is viewed as a death sentence, and families request nondisclosure to defend the patient from demoralization or early demise, in consistence with this, Hurteau et al. (2019) suggested in their study that the public should also be further educated on palliative care, as a more knowledgeable populace could result in less opposition and misconceptions regarding this field of medicine.

A significant finding showed the shortage of human resources (nurses and assistant nurses), the intensive work shifts, and consequent fatigue as barriers to nursing presence. Mojarad et al. (2018) emphasized these findings through a qualitative study that aimed to identify the barriers to the nursing presence in oncology care units, which revealed dissatisfaction and demotivation to work in the oncology unit due to a shortage of nurses is not enough, shortage of assistant nurses forces the trained nurses to do non-specialized work such as transportation of patients, and this leaves them no time to spend with patients. Lack of education and training programs to prepare nurses working in oncology and palliative settings derived participants to provide inadequate quality of care. Kgosana et al. (2019) have also emphasized the identified need for oncology nurses for psychological support arises to help them deal with the emotional challenges they come across when providing care to patients with cancer because oncology care is a specialized subset of nursing; it requires a correspondingly higher level of training and education.

According to this study, family was found to play a significant role as caregivers during the disease progression of terminally ill patients. Their role as caregivers was considered one of the factors that may cause moral distress for nurse participants. The represented family members of dying patients have not infrequently reported unmet needs regarding their needs for information about their relative's changing condition, the process of dying, how symptoms would be managed, and what to do at the time of death (Clark, 2017). This also aligned with Bush et al. (2017), who noted that terminally cancer patients' families have also identified their own needs for emotional and practical support over the time their family member died. This is because families are greatly reassured when they perceive their family member has received appropriate attention, ensuring the terminal symptoms of pain, breathlessness, agitation and delirium are as well managed as possible. Families can help patients make better decisions about their care plan and can join as partners to communicate with the healthcare team. Meanwhile, patients can decide the type of help they need and want from their families when making decisions. Additionally, communication between family caregivers and the health care team should continue throughout the care plan. It should include information about the treatment goals, patient care plans, and what to expect over time (Institute, 2021). Traboulssi et al. (2022) reflected the cultural beliefs and impacts of knowledge deficits amongst Bahraini families and Arab region that influenced the way spouses and their wives perceived cancer and dealt with it. Also, their research result showed that participant's culture led them to view cancer as incurable and as a death sentence, and it was associated with a negative stigma in society, consequently participants and their families hiding the truth about diagnosis.

Research findings showed that the family's role in hiding the truth of the disease diagnosis, prognosis, and treatment plan was found to be a source of moral distress to nurse participants. On the contrary, Hippocrates' notes showed that truth-telling or accurate information provision to patients about the outcome of an illness could aggravate prognosis (Ehsani et al., 2016), Nasrabadi et al. (2020) conducted a study which was aimed to explore the nurses' experience of white lies during cancer patient care, findings showed that nurses might feel compelled to use a white lie during patient care due to factors such as the crisis of hope, bad news, cultural diversity, and nurses' limited professional competence.

Nurse participants in this study explained a set of organizational factors affecting their experience, such as a lack of chemotherapy agents that delay a patient treatment cycle, maintain the stability of disease progression, or control some physical suffering, and hospital policy to do cardiopulmonary resuscitation (CPR) for dying terminally ill patients. Thus, those organizational factors came against staff nurses' morals, placing them in conflict and distress. Nwozichi and Ojewole (2015) and Willard & Luker (2007) also indicated that support from healthcare organizations and nursing administration could act as a buffer to decrease work stress and is health-protective for oncology nurses. A qualitative, descriptive, and explorative study conducted by Pettersson et al. (2020) revealed the ethics of "Do Not Resuscitate"- (DNR) -decisions in oncology and hematology care based on 287 free-text comments in a study-specific questionnaire showed that DNR decisions in oncology and hematology care gave rise to ethical considerations, crucial ethical values explained by the participants were to avoid harming to patients and to secure a peaceful and "natural" death with dignity for their dying patients, A preference for the statement "allows for natural death" instead of the traditional term "do not

resuscitate” was found in the material. This emphasized participants’ opinion to not resuscitate a terminal cancer patient who is dying but against SMC rules and regulations.

Also, the workload was identified as the highest source of work stress among participants and has been linked to staff shortage among oncology nurses, lack of chemotherapy agents, and delaying patient chemotherapy sessions. This finding is consistent with the study among Iranian oncology nurses; researchers indicated that role conflicts, lack of control, and organizational barriers, such as oncology nurse shortages, facility and equipment limitations, and underpayment, were significant sources of work stress which negatively affected the quality of nursing care (Iranmanesh, 2012), Ko and Kiser-Larson (2016) emphasized that in the USA nurses working in oncology outpatient units viewed staff shortage to be one of the highest work-related stressors for oncology nurses.

5.4 Chapter Summary

This chapter presents the findings that emerged from data which reflect oncologist nurse experiences in the Kingdom of Bahrain. Data displayed from the lens of the context of Bahrain and compared and contrasted with those in current literature, and analyses similarities and differences in nurses’ experiences. The next chapter presents the conclusion and recommendations that communicate the research findings with the new evidence-based practice to improve and fill gaps in practice for their experience.

Chapter VI

Conclusion, Limitation and Recommendations

CONCLUSION, LIMITATIONS, AND RECOMMENDATIONS

Conclusion

This study intended to explore and understand oncology nursing care for terminally ill patients in two oncology settings (inpatient and outpatient) in Bahrain. Using a qualitative method design helped accomplish the study's aim and objectives of providing in-depth knowledge of nurses' experience while caring for terminally ill patients in SMC-oncology units.

Qualitative findings discovered the emotions and moral distress experienced by oncology nurses while caring for terminally ill patients. Factors that influence their care and impact them negatively or positively.

Qualitative findings revealed three main categories of "nurse experience with terminally ill patients" are care" and three significant Categories: exhausting versus rewarding experienced feelings. These included two subthemes, Positive emotions and negative feelings. The second explained factors influencing Nursing care, which included three sub-categories, nurse characteristics, intra and Interprofessional Communication, and patient characteristics. The last theme explained the moral distress experienced by nurse participants, which contained three sub-categories, inadequate quality of care, family caregiver role, and management of ethical issues. Moreover, research findings help to indulge the recent experience of nurses with terminally ill patients, and that found to be practiced and experienced globally.

Further contributions of this research paper are to enhance care for terminally ill patients, establish an educational and training program, initiate a policy to

guide proper practice, and involve nursing schools in Bahrain for further preparation about cancer cases and stages.

Recommendation of the Study:

This study can be retained within the developing body of nursing knowledge, skill, and perception of how nurses experience the challenges and barriers while caring for terminally ill cancer patients. Moreover, the research findings urge for:

- Establishing adequate training for staff nurses, pre-recruitment in oncology units, newly joined oncology units, or even senior staff nurses. The target is to provide expert oncology nursing care for cancer patients, specifically those with terminal stages, through developing and implementing innovative interventions and strategies to enhance oncology nursing education and training in end-of-life periods.
- Involving effective nursing administration, training, and research to improve evidence-based care are some of the broad roles the oncology nurse must fulfil.
- Creating effective management, leadership, and counselling programs for oncology nurses providing care for terminally ill patients to ensure ultimate nursing efficacy and better patient outcomes by increasing the quality of care and advocating innovative interventions for terminally ill patients.
- Forming a train-the-trainee initiative to train other nurses in cooperation with the educational institute in Bahrain and abroad in the administration of palliative chemotherapy to patients, managing side effects of chemotherapy, and health education of patients and their families about the disease, treatment process, and side effects.

- Encouraging further studies to explore interventions to help overcome the challenges and obstacles impeding nurses from providing high-quality oncology nursing care in the hospital setting for terminally ill patients.
- Endorsing policymakers in SMC to consider oncology nursing are invited for further investigation, observation, and interviewing to identify causative and contributive factors related to emotional exhaustion.
- Involving SMC administration in pinpointing the matters of staff shortage, lack of chemotherapy agents, and opening counselling sessions for nurses and other health care providers.
- Integrating concepts of death, dying, and EoL care in all nursing academic and practical areas could impact the quality of care delivered during the terminal stage of a person's life.
- Developing a continuous oncology and end-stage care education program at the Salmaniya Medical Complex to enhance nurses' motivation toward a rewarding novice to expert nurse journey in caring for dying patients.

Limitations of the study

Generalizability is not intended to achieve in qualitative study. However, transferability implies the finding of a research can apply or transfer beyond the bounds of the research and enables researcher in another context to carry out a study with utilizing certain concepts which were initially developed. The researcher is an oncology nurse, so the chance for external bias occurs during data collection and analysis but is supported by the supervisor meeting and content integrity maintained via the application of Lincoln and Guba's (1985) criteria of rigour and trustworthiness to be avoided. Another limitation was that the language used for the interview was English, and the majority of participants were Bahraini and faced difficulties in proceeding in the English language, leading some interviewees to withdraw from the study, which affected the input of the study. Some faced problems with the interview language and could not conduct a full interview in English. The time element contributed, as some could not spend 60 to 90 minutes on an interview. The interview time was divided into several days, which is an effort and time-consuming for the interviewer and participants.

Chapter VII

Summary

SUMMARY

This study was conducted at the kingdom of Bahrain at Salmaniya Medical complex, specifically in the oncology department, to explore staff nurse experiences while providing care for terminally ill patients. The study took place in different settings, including inpatient and outpatient.

Data was collected through individual face-to-face interviews with oncology nurses. In faith of researchers to explore their perception of end-of-life care, their experience while providing care for terminally ill patients, and the impact of those patients on the quality of the care provided by oncologist nurses.

In addition, the researcher used an interview topic guide and protocol for a semi-structured interview to ensure the flexibility that allows modifying the order and details of topics to be covered and probing to direct conversation while maintaining the participants' narrative steer.

The sample size for this research was primarily 20 participants, but factually 15 participants only participated in semi-structured interviews, as data saturation gained, and no new idea occurred. Purposive sampling techniques were applied.

Data were analyzed using Braun and Clarke's 2006 thematic analysis model without pretexting. The researcher transcribed and documented the audio interviews in a verbatim form through Microsoft Word (2016) immediately after the completion of each interview. In addition, all interviews were transcribed within 24-72 hours of interview time. Initially, the researcher started the verbatim documentation by playing the audiotape and writing it in

Word. All interviews were shared with the research supervisor (research team) to seek feedback and verification against the audiotape recordings.

According to Braun and Clarke (2006), the data analysis process in the thematic analysis is under the classifications of generating initial codes, defining and naming themes, reviewing themes, and searching for themes. The researcher approached data in an interactive process; data analysis started earlier concurrently with the data collection process, which helped the researcher to see and make sense of integrated nonverbal cues for each participant.

A summary of the participants' demographics (age, gender, nationality, position, and marital status). The participants' working experience ranged from less than three to more than 15 years. Their ethnicities are Bahraini (n=10) and Indian (n=5). Among the 15 participants, one was a male nurse. Participants had different positions, but most were specialist nurses (n=10).

Analyzed data exhibited the experience of nurse participants, which has been collected and categorized according to the Braun & Clarke (2006) thematic analysis. The themes and sub-themes that emerged during data analysis. The correlated concepts were unified under three main core themes and eight sub-themes. Three key themes emerged from thematic analysis: (1) exhausting versus rewarding experienced feelings; (2) Factors influencing Nursing care; (3) Moral Distress.

Data trustworthiness reported by adopting Lincoln and Guba's 1985 model developed four quality criteria for the reliability of qualitative research: credibility, dependability, confirmability, and transferability to ensure validity and transferability of the data to other settings.

The provision of nursing care and their experience in multi-care settings remained challenging. This is partly due to the characteristics of patients, families, and healthcare workers and organizational factors such as lack of training, educational program, or even supportive policy.

End-of-life care in the Kingdom of Bahrain reflects and has been influenced by basic total nursing care. Oncology nurses reported suffering but also benefiting from their experiences. End-of-life cancer care training is needed and urged by oncology nurses, especially for those who are younger and less experienced. Also, future studies are mandated to explore interventions to help overcome the challenges impeding nurses from providing high-quality care for terminally ill patients in the kingdom of Bahrain.

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APPENDICES

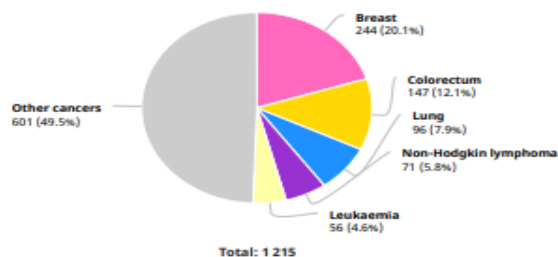
Appendix 1: Cancer Prevalence in Kingdom of Bahrain

Bahrain

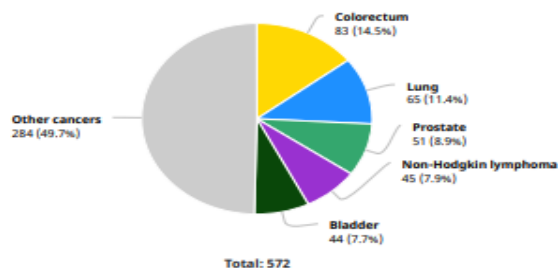
Source: Globocan 2020



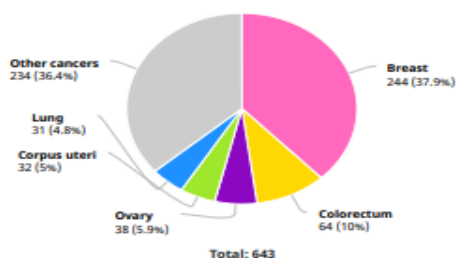
Number of new cases in 2020, both sexes, all ages



Number of new cases in 2020, males, all ages



Number of new cases in 2020, females, all ages



Summary statistic 2020

	Males	Females	Both sexes
Population	1 100 474	601 109	1 701 583
Number of new cancer cases	572	643	1 215
Age-standardized incidence rate (World)	108.5	130.7	112.2
Risk of developing cancer before the age of 75 years (%)	11.2	14.1	12.2
Number of cancer deaths	312	281	593
Age-standardized mortality rate (World)	68.1	65.6	64.3
Risk of dying from cancer before the age of 75 years (%)	6.5	7.4	6.8
5-year prevalent cases	1 454	1 926	3 380
Top 5 most frequent cancers excluding non-melanoma skin cancer (ranked by cases)	Colorectum Lung Prostate Non-Hodgkin lymphoma Bladder	Breast Colorectum Ovary Corpus uteri Lung	Breast Colorectum Lung Non-Hodgkin lymphoma Leukaemia

Geography



Numbers at a glance

Total population

1 701 583

Number of new cases

1 215

Number of deaths

593

Number of prevalent cases (5-year)

3 380

Data source and methods

Incidence

Country-specific data source: Bahrain National Cancer Registry

Method: National (or local with coverage greater than 50%) rates projected to 2020

Mortality

Country-specific data source: National (WHO)

Method: Estimated from national incidence estimates by modelling, using incidence:mortality ratios derived from cancer registry data in neighbouring countries

Prevalence

Computed using sex-, site- and age-specific incidence to 1-,3- and 5-year prevalence ratios from Nordic countries for the period (2006-2015), and scaled using Human Development Index (HDI) ratios.

Appendix 2: Nursing Manpower at SMC 2015-2020

جدول 04 القوى العاملة بالمعديين الطبية والمساندة حسب الفئة والجنسية
2020 - 2015
Medical and Allied Health Manpower by Category and Nationality 2015 - 2020

Category	2020	2019	2018	2017	2016	2015	الجنسية Nationality	الفئة
Physicians	949 150 1,099	860 160 1,020	922 169 1,091	947 179 1,126	999 188 1,187	1,073 Bah 197 Non-Bah 1,270 Total	بحريني غير بحريني الجملة	الاطباء
Dentists	107 12 119	99 11 110	110 11 121	111 14 125	119 15 134	123 Bah 11 Non-Bah 134 Total	بحريني غير بحريني الجملة	اطباء الأسنان
Pharmacists & Technicians	230 14 244	211 15 226	213 15 228	197 15 212	200 15 215	208 Bah 14 Non-Bah 222 Total	بحريني غير بحريني الجملة	الصيادلة وفنيو صيدلانية
Nurses	1736 2178 3,914	1561 1396 2,957	1758 1467 3,225	1686 1514 3,200	1,682 1,560 3,242	1,744 Bah 1,598 Non-Bah 3,342 Total	بحريني غير بحريني الجملة	الممرضين
Practical Nurses	13 - 13	15 - 15	43 - 43	51 - 51	65 - 65	80 Bah - Non-Bah 80 Total	بحريني غير بحريني الجملة	الممرضين العمليين
Dental Hygienists & Technicians	66 66 -	60 60 -	75 75 -	79 79 -	78 78 -	82 Bah - Non-Bah 82 Total	بحريني غير بحريني الجملة	فنيو صحة الفم والأسنان
Laboratory Technologists and Technicians	275 44 319	227 33 260	253 34 287	245 35 280	255 35 290	272 Bah 23 Non-Bah 295 Total	بحريني غير بحريني الجملة	مختبر وفنيو مختبر
Radiographers and Technicians	112 10 122	106 10 116	119 13 132	115 14 129	125 14 139	126 Bah 15 Non-Bah 141 Total	بحريني غير بحريني الجملة	مصورو وفنيو أشعة
Physiotherapists, Occupational Therapists and Technicians	133 1 134	129 1 130	138 1 139	134 1 135	134 2 136	130 Bah 2 Non-Bah 132 Total	بحريني غير بحريني الجملة	فنيو علاج طبيعي وتأهيل مهني
Prosthetic, Orthotics Technicians	16 4 20	19 6 25	19 8 27	17 8 25	20 9 29	21 Bah 9 Non-Bah 30 Total	بحريني غير بحريني الجملة	فنيو أطراف صناعية وعظام
Anaesthesia Technician	1 35 36	1 24 25	3 27 30	5 28 33	5 30 35	7 Bah 31 Non-Bah 38 Total	بحريني غير بحريني الجملة	فنيو التخدير

Appendix 3: Bed Status at Salmaniya Medical Complex

	A	B	C	D	E	F	G	H	I
1	SALMANIYA MEDICAL COMPLEX								
2	BED STATUS-AUGUST 24 2021								
3	WARD	SPECIALTY	TOTAL	MALE	FEMALE	OCCUPIED	VACANT	OCCUP%	
4	WARD 4	T.B WARD	17	5	3	8	9	47%	
5	WARD 011	SURGICAL SPECIALTIES	8	5	0	5	3	63%	
6	WARD 011 HD	SURGICAL HD	6	2	0	2	4	33%	
7	WARD 012	TRANSIENT WARD	25	9	4	13	12	52%	
8	WARD 021	SCD-FEMALE	20	0	17	17	3	85%	
9	WARD 022	SURGICAL MULTISPECIALTY	16	4	12	16	0	100%	
10	WARD 023	ORTHOPEDICS	20	18	0	18	2	90%	
11	WARD 024	PEDIATRIC ICU	8	0	1	1	7	13%	
12	WARD 031	PEDIATRICS	21	8	7	15	6	71%	
13	WARD 032	PEDIATRICS	14	3	7	10	4	71%	
14	WARD 033	ENT+OPHTHALMOLOGY	22	8	4	12	10	55%	
15	WARD 034	PEDIATRICS-UNDER - 1 YR	21	8	8	16	5	76%	
16	WARD 035	PEDIATRICS	14	6	0	6	8	43%	
17	WARD 036	PEDIATRICS - INFECTIOUS	21	5	4	9	12	43%	
18	WARD 041	MULTI SPECIALTY WARD	22	19	0	19	3	86%	
19	WARD 042	MULTI SPECIALTY WARD	16	6	10	16	0	100%	
20	WARD 043	MULTI SPECIALTY WARD	22	17	0	17	5	77%	
21	WARD 044	SCD-MALE	22	20	0	20	2	91%	
22	WARD 045	MULTI SPECIALTY WARD	16	10	5	15	1	94%	
23	WARD 046	MULTI SPECIALTY WARD	22	0	21	21	1	95%	
49	WARD 208 CCU	CARDIAC CCU	8	3	4	7	1	88%	
50	WARD 307	NICU	27	14	5	19	8	70%	
51	WARD 308	LABOUR WARD	16	0	13	13	3	81%	
52	WARD 309	NICU	24	11	8	19	5	79%	
53	WARD 310	OBSTETRICS & GYNECOLOGY	20	0	19	19	1	95%	
54	WARD 311	OBSTETRICS & GYNECOLOGY	20	0	17	17	3	85%	
55	WARD 312	MEDICAL SPECIALTIES	20	12	7	19	1	95%	
56	WARD 407	OBSTETRICS & GYNECOLOGY	16	0	16	16	0	100%	
57	WARD 408	OBSTETRICS & GYNECOLOGY	20	0	20	20	0	100%	
58	WARD 409	SURGICAL MULTISPECIALTY-FEMALE	20	0	14	14	6	70%	
59	WARD 410	OBSTETRICS & GYNECOLOGY	20	0	18	18	2	90%	
60	WARD 411	MEDICAL-MULTI SPECIALTY WARD	20	11	6	17	3	85%	
61	WARD 412	MEDICAL-MULTI SPECIALTY WARD	18	13	5	18	0	100%	
62	WARD 413	PRIVATE WARD	12	3	6	9	3	75%	
63	WARD H1	COVID19-POSITIVE	21	3	0	3	18	14%	
64	WARD H2	COVID19-POSITIVE	21	1	3	4	17	19%	
65	WARD H3	COVID19-POSITIVE	22	1	0	1	21	5%	
66	WARD H4	COVID19-POSITIVE	22	0	4	4	18	18%	
67	WARD SEH1	COVID19-POSITIVE	37	0	0	0	37	0%	
68	WARD SEH2	COVID19-POSITIVE	25	0	0	0	25	0%	
69	WARD SEH3	COVID19-POSITIVE	37	0	0	0	37	0%	
70	TOTAL SMC BEDS		1238	342	344	686	552	55%	
71									

NURSING MANPOWER



i You forwarded this message on Thu 10/14/2021 10:03 AM



Ansaf Sayed Ehsan Almoosaw <AMosawi@health.gov.bh>



To: Layla Salman Matrook

Thu 9/23/2021 11:24 AM

الأخت الفاضلة / ليلى سلمان متروك المحترمة
تحية طيبة وبعد،

الجدول أدناه يوضح عدد القوى العاملة التمريضية في مستشفى السلمانية الطبي حسب مركز التكلفة، وذلك بناءً على طلبكم.

CATEGORY	TOTAL STAFF
NURSING STAFF	2364
MEDICAL SERVICES AIDE	332
Grand Total	2696

مع خالص تحياتي،،
إنصاف إحصان الموسوي
أخصائي موارد بشرية أول
إدارة الموارد البشرية والمالية
وزارة الصحة
رقم المكتب 17286568

Appendix 5: Ethical Approval of UoB Scientific Research and Publication Committee



**University of Bahrain
College of Health and Sports Sciences
Scientific Research and Publication Committee**

October 21, 2021

To: The Chairperson of the Research Technical Support Team
Ministry of Health
Kingdom of Bahrain

Dear Madam/Sir,

Greetings from the College of Health and Sport Sciences, University of Bahrain!

RE: Research study on "An Exploratory Qualitative Study of Oncology Nurses' Experience in Providing Care for Terminally Ill Patients in Kingdom of Bahrain at Salmanya Medical Complex"-
CHSS SRPC Recommendation No: 3/2021-22 dt. Oct 21,2021.

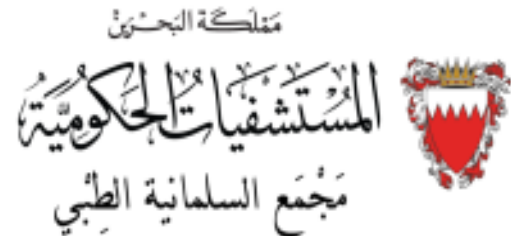
The Scientific Research and Publication Committee, College of Health and Sport Sciences (CHSS), University of Bahrain (UOB), has reviewed and recommended the research proposal (CHSS SRPC Recommendation No: 3/2021-22 dt. October 21, 2021) entitled "An Exploratory Qualitative Study of Oncology Nurses' Experience in Providing Care for Terminally Ill Patients in Kingdom of Bahrain at Salmanya Medical Complex" to the MoH RTST. Ms.Layla Salman Turki, a student enrolled in M.Sc Adult Health Nursing -Nursing Program of CHSS, UoB would be carrying out the study under the supervision of Dr. Leena Khonji, Chairperson, Nursing Department, and Dr.Magda Bayoumi, Assistant Professor, Nursing Department, CHSS, UoB as Master's Thesis. Notably, the outcome of the research is expected to benefit the terminally ill patients admitted in the Kingdom of Bahrain through improved nursing care. Therefore, I request to do the needful considering the paucity of time to complete the Master's Thesis.

Thank you for supporting scientific research at the CHSS, UOB.

Kind Regards,

Chairperson, Scientific Research and Publication Committee
College of Health and Sport Sciences
University of Bahrain

Appendix 6: Ethical Approval from Research & Research Ethics Committee for Government Hospitals



Research Proposal Approval

Dear **Layla Almatrook,**

We would like to inform you that the **Research & Research Ethics Committee for Government Hospitals** has approved your research proposal:

"An Exploratory Qualitative Study of Oncology Nurse's Experience in Providing Care for Terminally Ill Patients in Bahrain"

Approval date 08/11/2021.

Research approval serial no: 122081121

We all wish you a successful research and request you to update us with its progress.

Regards,

Eman Farid



Appendix 7: Informed Consent



University of Bahrain
College of Health and Sports Sciences
Scientific Research and Publication Committee

Informed Consent

I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study. |

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

Appendix 8: Participants Sheet



University of Bahrain
College of Health and Sports Sciences
Scientific Research and Publication Committee

Participant Sheet

You are being invited to participate in a study to explore your experience with terminally ill patient at outpatient department, your experience and opinions will be discussed and taken into consideration

TITLE OF STUDY

An Exploratory Qualitative Study of Oncology Nurses' Experience in Providing care for Terminally Ill Patients in Kingdom of Bahrain

PRINCIPAL

INVESTIGATOR

Layla Salman Turki Matrook

Address: College of Health and Sport Sciences, University of Bahrain, P.O. Box 32038, 17437777

Nursing Department

Phone: 39776166

E-mail: layla.turki@hotmail.com

Supervisors:

- Dr. Leena Mohamed Abdulla

E- mail: lkhonji@uob.edu.bh

- Dr. Magda Mohamed Bayoumi

E-mail: mbayoumi@uob.edu.bh

PURPOSE OF STUDY

You are being asked to take part in a research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will involve. Please read the following information carefully. Please ask the researcher if there is anything that is not clear or if you need more information.

The purpose of this study is intent to explore the experience of oncology staff nurses in providing care for terminally ill patients.

STUDY PROCEDURES

This research study will use a semi- structure interview with open- ended and propping questions that will take place at Salmaniya Medical Complex – oncology outpatient unit. the interviews will be proceed after taking permission from the head of oncology unit, at calm, privet room, and the time of interview will be between up to 90 minutes and may take longer time depends on participants answer and explanation to interview question. Also, Content of the interview will be recorded via Integrated Circuit record (IC record) with the participants' consent, and a verbatim record will be used for later thematic analysis and to make sure not missing any data from participant.

BENEFITS

The benefit of this study is to improve the quality of care provided by staff nurses at oncology department for cancer patient in terminal stage.

CONFIDENTIALITY

For the purposes of this research study, your comments will not be anonymous. Every effort will be made by the researcher to preserve your confidentiality including the following:

- Numbers for each participants that will be used on all research notes and documents,
- Notes, interview transcriptions, and any other identifying participant information will be placed in a locked file cabinet in the University of Bahrain and password-protected system computer.

Your data will be kept confidential except in cases where the researcher is legally obligated to report specific incidents. These incidents include, but may not be limited to, incidents of abuse and suicide risk.

CONTACT INFORMATION

If you have questions at any time about this study, or you experience adverse effects as the result of participating in this study, you can contact the researcher whose contact information is provided on the first page. If you have questions regarding your rights as a research participant, or if problems arise which you do not feel you can discuss with the Primary Investigator, please contact the research supervisors Dr. Leena Abdulla and Dr. Magda Mohamed.

VOLUNTARY PARTICIPATION

Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you decide to take part in this study, you will be asked to sign a consent form. After you sign the consent form, you are still free to withdraw at any time and without giving a reason. Withdrawing from this study will not affect the relationship you have, if any,

with the researcher. If you withdraw from the study before data collection is completed, your data will be destroyed.

Yours sincerely,

St/N: Layla Salman Turki (Principle researcher)

قانون حماية البيانات الشخصية

الباب الأول

أحكام المعالجة

الفصل الأول

أحكام تمهيدية

مادة (١)

تعاريف

يُطبق أحكام هذا القانون، يكون للكلمات والعبارات التالية المعاني المبينة قرين كل منها، ما لم يقتض سياق النص خلاف ذلك:

بيانات أو بيانات شخصية: أية معلومات هي أية صورة تخص فرداً مُعرّفاً، أو قابلاً بطريق مباشر أو غير مباشر لأن يُعرّف، وذلك بوجه خاص من خلال رقم هويته الشخصية أو صفة أو أكثر من صفاته الشكلية أو الفسيولوجية أو الذهنية أو الثقافية أو الاقتصادية أو هويته الاجتماعية. ولتقرير ما إذا كان الفرد قابلاً لأن يُعرّف، تراعى كافة الوسائل التي يستخدمها مدير البيانات أو أي شخص آخر، أو التي قد تكون متاحة له.

بيانات شخصية حساسة: أية معلومات شخصية تكشف على نحو مباشر أو غير مباشر عن أصل الفرد العرقي أو الإثني أو آرائه السياسية أو الفلسفية أو معتقداته الدينية أو انتمائه النقابي أو سجل السوابق الجنائية الخاص به أو أية بيانات تتعلق بصحته أو حالته الجنسية.

المعالجة: أية عملية أو مجموعة عمليات يتم إجراؤها على بيانات شخصية بواسطة آلية أو غير آلية، ومن ذلك جمع تلك البيانات أو تسجيلها أو تنظيمها أو تصنيفها في مجموعات أو تخزينها، أو تحويلها أو تعديلها، أو استعادتها أو استخدامها أو الإفصاح عنها، من خلال بثها أو نشرها أو نقلها أو إتاحتها للغير، أو دمجها أو حجبها أو مسحها أو تدميرها.

مطلومة ملفات: أية مجموعة بيانات شخصية لا تعالج بواسطة جهاز يعمل آلياً بناءً على تعليمات تُعطى له ولكنها مرئية على نحو يتيح الحصول منها على معلومات عن الأفراد الذين تخصّصهم هذه البيانات.

الشخص: أي شخص طبيعي أو اعتباري، بما هي ذلك أية جهة عامة.

الفرد: أي شخص طبيعي.

مدير البيانات: الشخص الذي يقرر، بمفرده أو بالاشتراك مع الآخرين، أغراض ووسائل معالجة بيانات شخصية معينة. وهي الحالات التي تكون فيها هذه الأغراض والوسائل مقرّرة

Appendix. 10: Semi-structured Interview Topic Guide Questions

University of Bahrain

College of Health and Sport Sciences

Department of Nursing

Semi-structured Interview about “Staff Nurses Experiences’ with Terminally Ill Patient at Oncology Department in Salmaniya medical Complex”.

This interview questions designed based on reviewing several literatures about same subject of research.

First, thank you for agreeing to participate in the interview. I am interviewing you to better understanding staff nurses practice and experience at oncology department and how we can improve the way we provide care for cancer patients with terminal stage. So there are no right or wrong answers to any of our questions, I am interested in your own experiences.

Second, Participation in this study is voluntary and your decision to participate, or not participate, will not affect the care your patients currently receiving treatment at oncology outpatient department.

Last, the interview should take approximately 90 min depending on how much information you would like to share. With your permission, I would like to audio record the interview because I do not want to miss any of your comments. All responses will be kept confidential. This means that your interview responses will only be shared with research committee and we will ensure that any information we include in our report does not identify you as the respondent. You may decline to answer any question or stop the interview at any time and for any reason. May I turn on the digital recorder?

General Question	Probe Question
Background It would be nice if you could tell me a little bit about yourself: - How many years of experience as staff nurse/ and at oncology department? - What is your job designation?	
Work Experience Now we will talk about staff nurses experience: - what is the general experience of oncology staff nurses' in providing care for terminally ill patient at the end of their life?	- To how extent the difference in oncology nurse personal characteristics can affect the care of terminally ill patients? - What are the challenges the oncology nurses are facing while providing care of terminally ill patients?
Factors affecting care Are there factors affecting your care for terminally ill patients?	- To what extent the patient's clinical characteristics (age, gender, cancer stage, medical history, etc...) affecting the oncology nursing care to terminally ill patient? - To how extent the patients' sociodemographic characteristics (marital status, religious, educational level, etc...) affecting the experience of oncology staff nurses in providing care for terminally ill patient?

	- can you identify the social characteristics of terminally ill patients that effect the experience of oncology staff nurses? - detect the effect of clinical manifestations and disease features for each terminally ill patient on the experience of oncology nurse? - To what extent the impact of family caregiver affecting the nursing care and treatment provided to terminally ill patient's care and treatment?
Communication skill Does oncology staff nurse own special communication skill?	- To how extent the therapeutic communication using by oncology nurses affecting the terminally ill patient's condition during receiving the care? - can you identify the effect of compassionate communication skill on the experience of oncology nurse with terminally ill patients,

Conclusion

Is there anything else that you would like to comment on that I haven't already asked you about?

Thank you very much for your time and the information you shared today.

Appendix 11: Mental Distress Guideline

What Can Be Done To Help A Person?

People experiencing these symptoms should seek medical help. Mental distress is like a physical illness. It is important to receive treatment in order to get well. If a person receives treatment at an early stage, they may be able to recover more quickly. One of the following or a combination can assist the person:

- **Medication** can help with some forms of mental distress. It helps to control symptoms.
- **Support and counseling** is talking to someone to deal with problems, to help to cope with the distress and the symptoms.
- **Support Group Meetings** and being with other people with mental distress. Families getting together who have a member with mental distress. These groups give people the chance to share experiences, learn about mental distress and support each other.

The aim of this help is to restore respect, dignity and confidence to the mentally distressed person.

Where Can I Get This Help?

- **Primary Care Provider**
Your doctor can check to make sure there are no underlying physical problems. They can medically treat the mentally distressed person. Your doctor can also refer you to other appropriate services.
- **Community Mental Health Clinics**
Staff include psychiatrists, psychologists, psychiatric nurses, occupational therapists, social workers. They offer different forms of help to the person with mental distress and/or their families. This can include crisis assistance.
- **Psychiatric Hospitals**
If someone is very sick they may need to be in hospital. People may be taken to hospital involuntarily if there is a risk that they can hurt themselves or others. Once a person is admitted to hospital, their mental health is reviewed regularly. The aim of a hospital admission is to restore a person's mental health as soon as possible so that they can return home.

Will My Problem Be Kept Confidential?

When seeing a health professional, information about your problem cannot be given to anyone else without your permission. If an interpreter is present they also must keep the information confidential. It is important for a person with mental distress to receive treatment in order to get well. The longer the distress remains untreated the longer it can take for the person to recover.

Where Can I Get More Information?

Ask your primary care doctor for more information.

If you, a family member or a friend has mental distress that is very severe and your primary care doctor is not available, you should go to the nearest hospital emergency room.

This information was adapted from a brochure titled "What is Mental Illness" produced by ADEC (Action on Disability within Ethnic Communities) Victoria, Australia.

Appendix 12: Table 3.1: searching for initial codes

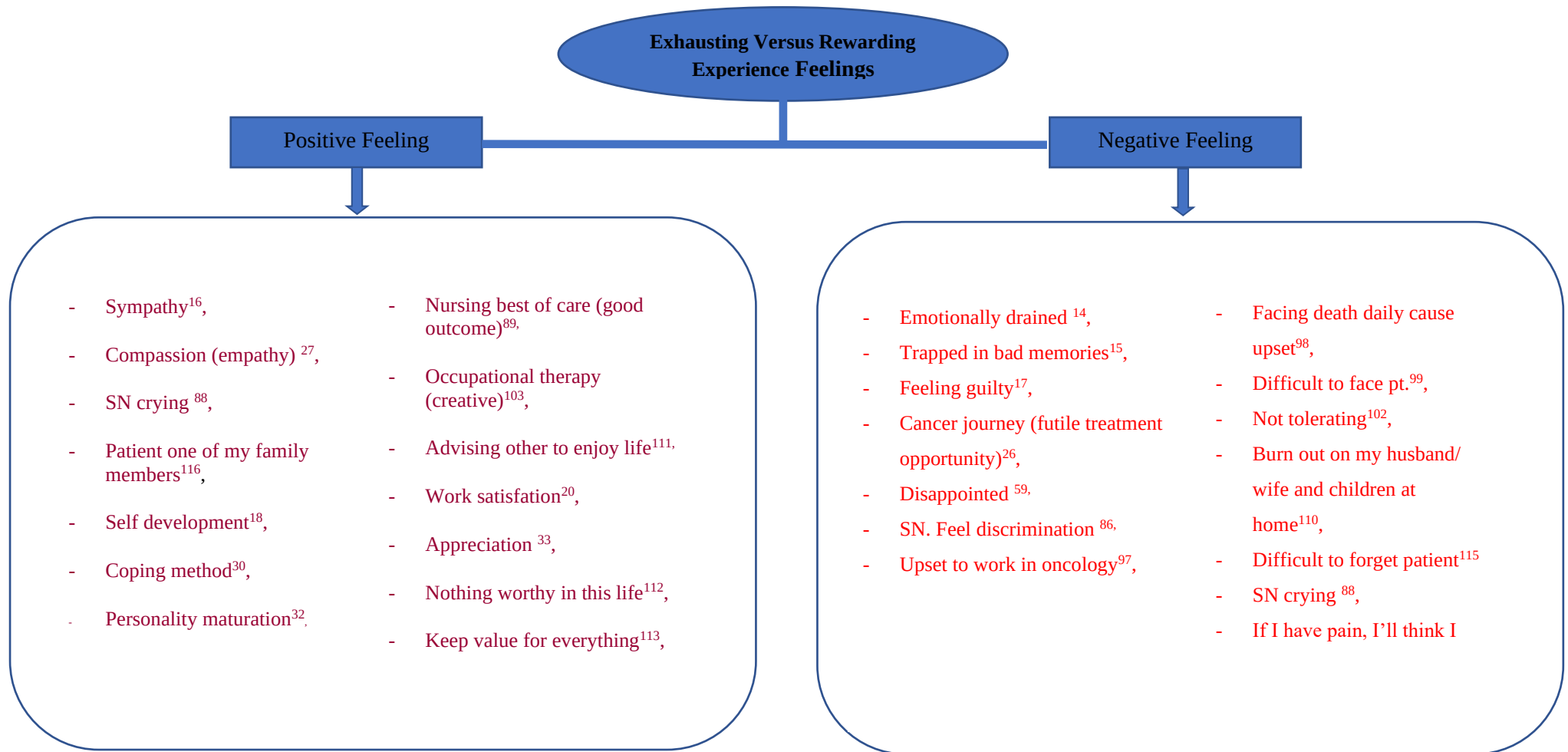
Participant code	Statements	Initial codes
P2	“After I moved to clinic, one more incident, the problem of our conflict mainly to our knowledge deficit in this feild (she means oncology-end stage).	Knowledge deficit ²³
P1	“Not, some patients not becoming ...because of...not because of chemo...ammm... or some other disease, our patient admitted with the sepsis and UTI”. (Participant perception about terminally ill patient).	
P3	“I remember the patient, he was walking patient, may be 40s or 50s, he will specifically find that time of the shift is only for female, he will ask the Indian staff exactly because he feel shame to ask Bahraini staff. I’m not racism.... he asked her (Indian staff nurse) can I book for bath? Like we are in hotel or spa. Can I book a bath for tonight? “But for my emotion of course it makes me, it made me more strong or more prepared for any type of shock”.	Harassment behavior from patient⁸¹ Personality maturation³²
P5	“oncology patient acute or terminal stage, you can see all factors affect nurses, I would not focusing in our culture...when they are diagnosed cancer its catastrophic and isolating experience.... cancer means in our culture we always have relation with cancer is a death sentence”	Community awareness ⁷² , Pt. cultural background ⁶⁹ ,
P13	They can’t understand (family) they can’t understand their pain (terminally ill patient). They can’t understand, aaa...I remember there was on patient, and she was in severe pain, her husband refusing to give her morphine and she was palliative... and he was thinking that about addiction. What addiction in this stage??” Sometimes, I mean if I set with them (terminally ill patients) specially end-of-life patients, they will talk to you. I mean they may be not sharing with their families. I set with some patient; they were telling me thing really I still remember.	Family interfering in nursing work¹⁰¹ Nurse-pt. trustful relationship³⁵

Appendix 13: Table 3.2: Themes and Sub-Themes with Their Associated Codes

Negative feeling Coeds: - Emotionally drained ¹⁴, - Trapped in bad memories¹⁵, - Feeling guilty¹⁷, - Cancer journey (futile)²⁶, - Disappointed ⁵⁹, - SN. Feel discrimination ⁸⁶, - Upset to work in oncology⁹⁷, - Facing death daily cause upset⁹⁸, - Difficult to face pt.⁹⁹, - Not tolerating¹⁰², - Burn out on my husband/ wife and children at home¹¹⁰, - Difficult to forget patient¹¹⁵, - If I have pain, I'll think I have same to the patient disease¹¹⁴.	Positive feeling Codes: - Sympathy¹⁶, - Compassion (empathy) ²⁷, - SN crying ⁸⁸, - Patient one of my family members¹¹⁶, - Self development¹⁸, - Coping method³⁰, - Personality maturation³², - Nursing best of care (good outcome)⁸⁹, - Occupational therapy (creative)¹⁰³, - Advising other to enjoy life¹¹¹ (, - Work satisfaction²⁰, - Appreciation ³³, - Nothing worthy in this life¹¹², - Keep value for everything¹¹³,	Management Ethical issues Codes: - Lack of educational session¹¹, - Lack of training program¹², - Work legislation²¹, - Training for palliative care ³⁹, - health institute inefficiency ⁴⁴, - manpower shortage ⁴⁵, - Health care facility mismanagement (health institute inefficiency 44) ⁹¹, - Need for special education and training to work with terminally il ⁹², - Hospital policy to do CPR¹⁰⁴, - No hospital policy for DNR¹⁰⁵, - Hospital policy avoid staff nurse to disclose information to patient ¹⁰⁶, - Lack of chemotherapy agent in hospital leading to delay treatment¹⁰⁷,
Inadequate Quality of care Codes: - Lack of choice² - Work conflict³, - workplace challenges⁴, - Unpleasant experince⁹, - Lack of experince¹⁰, - Lack of Knowledge ²³, - Work environment setting (IN/OUT)²⁴, - Health care institute effort⁷⁰, - Community awareness ⁷², - Language barrier ⁷⁴, - Difficult to tell patient¹⁰⁸, - religious diversity ⁵⁰. - Decrease quality of care ⁸⁷, -	Intra and interprofessional communication Codes: - Miscommunicate⁵, - Trust among team¹⁹, - Respect among team⁷, - Communication with doctor ¹³, - Communication with family²², - Nurse-pt. relationship³¹, - Nurse-pt. trustful relationship³⁵, - Nurse body language³⁶, - Nurse mental attendance³⁷, - supportive touch⁴⁰, - Effective communication with colleagues ⁵⁶, - SN- Pt. boundaries in relationship ⁹⁰,	nurses' characteristics Codes: - SN acceptance⁶, - Years of experience ¹, - - Motivation to work with terminally ill patient⁸, - Coaching among nursing team²⁵, - Self-control ²⁸, - Basic nursing care ³⁴, - Sense of humor³⁸, - holistic care⁴², - physical-psychological support for family ⁴³, - nurse educational background ⁵¹, - SN behavior⁵⁴, - Professionalism⁵⁵,

	- Open-frank conversation ⁹³, - Limited – restricted conversation ⁹⁴. -	- Pt. psychological and emotional support ⁶¹, - Pt. spiritual support ⁶², - Oncologist nurse characteristics ⁶³, - Oncologist nurse obligations ⁷³, - Respecting Pt. decision ⁷⁵, - Coaching and education for Pt. ⁷⁶, - Nurse supervisor role and responsibilities⁸⁵, - SN perception about terminally ill⁹⁵, - Training for chemo-installation ⁹⁶.
Positive versus negative impact of terminally ill patient and their family on staff nurse Codes: -	Family caregiver role Codes: - Family supportive role ⁶⁴, - Family hiding truth ⁶⁵, - Family taking decision instead of pt. ⁶⁶, - Relative denying stage ⁶⁸, - Relative attitude (perception)⁷¹, - Relative conflict and dissatisfaction ⁷⁷, - Relative blaming ⁷⁸, - Family neglecting ⁷⁹, - Family impact on SN (positive / negative) ⁸⁰, - Family interfering in nursing work¹⁰¹.	Patients' characteristics Codes: - Pt. age ²⁹, - pt. needs⁴¹, - socioeconomic burden ⁴⁶, - patient behavioral changes⁴⁷, - pt. wrong decision ⁴⁸, - refusal for treatment ⁴⁹, - pt. religious background⁵², - pt. rejection for SN ⁵³, - Pt. health status changes ⁵⁷, - Pt. gender ⁵⁸, - Pt. wishing ⁶⁰, - Pt. awareness about their condition ⁶⁷, - Pt. cultural background ⁶⁹, - Harassment behavior from patient⁸¹, - Pt. behavior and attitude⁸², - Pt. impact on SN (POSITIVE/NEGATIVE)⁸³, - Pt. medical history⁸⁴, - Terminally ill suffering¹⁰⁰.

Appendix 14: Table 3.3 Reviewing the themes



Factors Influencing Nursing Care

Nurses' Characteristics

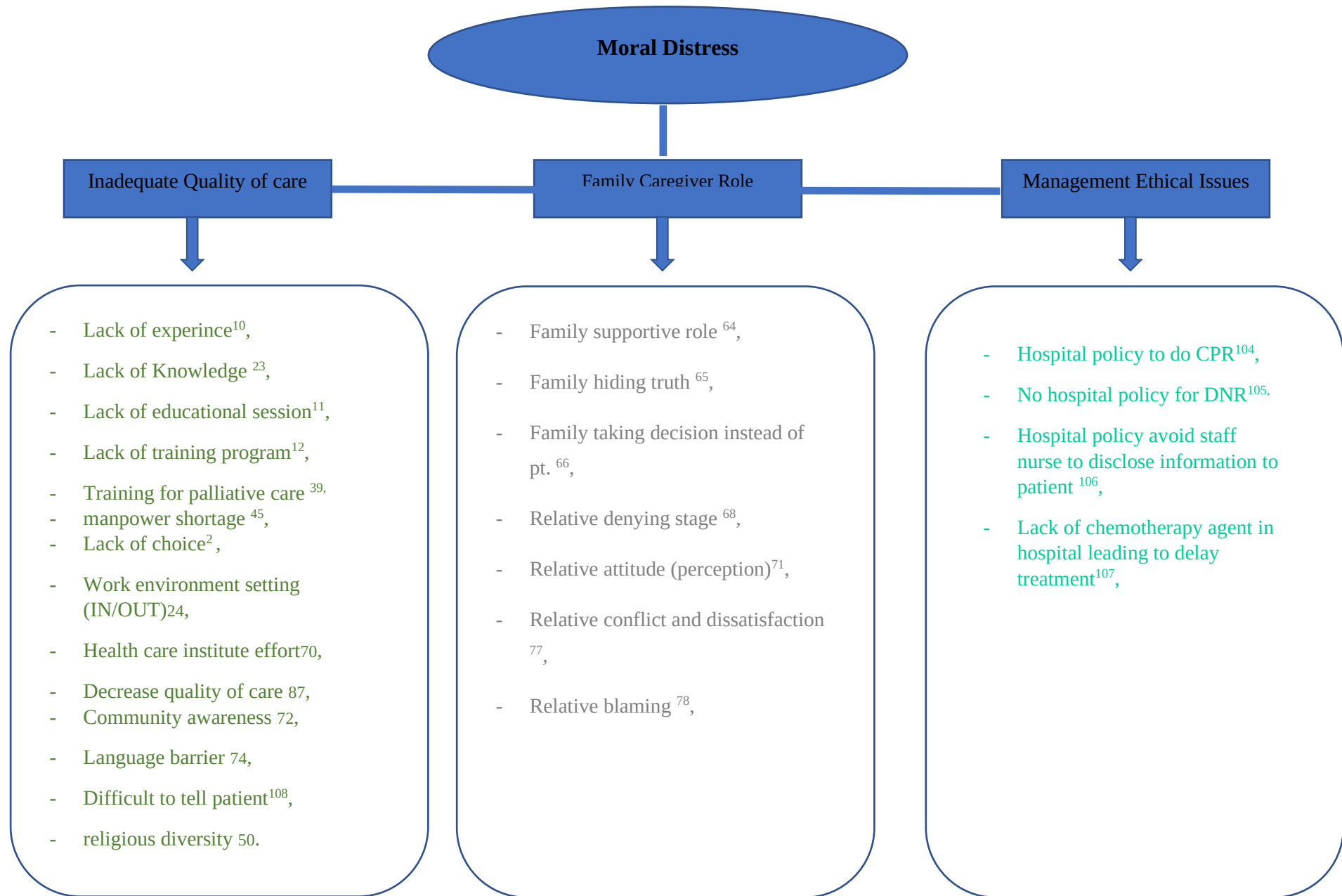
- SN acceptance⁶,
- Years of experience ¹,
- Motivation to work with terminally ill patient⁸,
- Coaching among nursing team²⁵,
- Self-control ²⁸,
- Basic nursing care ³⁴,
- Sense of humor³⁸,
- holistic care⁴²,
- physical-psychological support for family ⁴³,
- nurse educational background ⁵¹,
- SN behavior⁵⁴,
- Professionalism⁵⁵,
- Pt. psychological and emotional support ⁶¹,
- Pt. spiritual support ⁶²,
- Oncologist nurse characteristics ⁶³,
- Oncologist nurse obligations ⁷³,
- Respecting Pt. decision ⁷⁵,
- Coaching and education for Pt.⁷⁶,
- Nurse supervisor role and responsibilities⁸⁵,
- SN perception about terminally ill⁹⁵,
- Training for chemo-installation ⁹⁶.

Intra and Interprofessional Communication

- Miscommunicate⁵,
- Trust among team¹⁹,
- Respect among team⁷,
- Communication with doctor ¹³,
- Communication with family²²,
- Nurse-pt. relationship³¹,
- Nurse-pt. trustful relationship³⁵,
- Nurse body language³⁶,
- Nurse mental attendance³⁷,
- supportive touch⁴⁰,
- Effective communication with colleagues ⁵⁶,
- SN- Pt. boundaries in relationship ⁹⁰,
- Open-frank conversation ⁹³,
- Limited – restricted conversation ⁹⁴.

Patients' Characteristics

- Pt. age ²⁹,
- pt. needs⁴¹,
- socioeconomic burden ⁴⁶,
- patient behavioral changes⁴⁷,
- pt. wrong decision ⁴⁸,
- refusal for treatment ⁴⁹,
- pt. religious background⁵²,
- pt. rejection for SN ⁵³,
- Pt. health status changes ⁵⁷,
- Pt. gender ⁵⁸,
- Pt. wishing ⁶⁰,
- Pt. awareness about their condition ⁶⁷,
- Pt. cultural background ⁶⁹,
- Harassment behavior from patient⁸¹,
- Pt. behavior and attitude⁸²,
- Pt. impact on SN (POSITIVE/NEGATIVE)⁸³,
- Pt. medical history⁸⁴,



ملخص الدراسة

أجريت هذه الدراسة في مملكة البحرين في مجمع السلمانية الطبي ، وتحديدًا في قسم الأورام ، لاستكشاف تجارب ممرضات الموظفين أثناء تقديم الرعاية للمرضى الميؤوس من شفائهم. أجريت الدراسة في أماكن مختلفة ، بما في ذلك الممرضين العاملين في أجنحة الأورام والعيادة الخارجية.

تم جمع البيانات من خلال مقابلات فردية وجها لوجه مع ممرضى الأورام، إيمانًا بالباحثين لاستكشاف تصورهم للرعاية في نهاية العمر، وتجربتهم أثناء تقديم الرعاية للمرضى الميؤوس من شفائهم ، وتأثير هؤلاء المرضى على جودة الرعاية المقدمة من قبل ممرضى الأورام.

بالإضافة إلى ذلك ، استخدم الباحث دليل موضوع المقابلة وبروتوكول المقابلة شبه منظمة لضمان المرونة التي تسمح بتعديل ترتيب وتفاصيل الموضوعات التي سيتم تغطيتها وكذلك التحقيق في المحادثة المباشرة مع الحفاظ على توجيه المشاركين السري.

كان حجم العينة لهذا البحث في المقام الأول 20 مشاركًا ، ولكن في الواقع شارك 15 مشاركًا فقط في المقابلات شبه المنظمة ، مع اكتساب تشعب البيانات ، و عدم ظهور أفكار جديدة، كما أنه تم تطبيق تقنيات أخذ و إختيار العينات الهادفة.

تم تحليل البيانات باستخدام نموذج التحليل الموضوعي لـ Braun and Clarke لعام 2006 دون ذريعة. قامت الباحثة بنسخ وتوثيق المقابلات الصوتية بشكل حرفي من خلال برنامج Microsoft Word (2016) فور الانتهاء من كل مقابلة. بالإضافة إلى ذلك ، تم تدوين جميع المقابلات في غضون 24-72 ساعة من وقت المقابلة. في البداية ، بدأ الباحث التوثيق الحرفي من خلال تشغيل الشريط الصوتي وكتابته في Word. تمت مشاركة جميع المقابلات مع مشرف البحث (فريق البحث) للحصول على التغذية الراجعة والتحقق من التسجيلات الصوتية.

وفقًا لـ (Braun and Clarke 2006) ، فإن عملية تحليل البيانات في التحليل الموضوعي تخضع لتصنيفات إنشاء الرموز الأولية ، وتحديد السمات وتسميتها ، ومراجعة السمات ، والبحث عن الموضوعات. تناول الباحث البيانات في عملية تفاعلية. بدأ تحليل البيانات في وقت سابق بالتزامن مع عملية جمع البيانات ، مما ساعد الباحث على رؤية وفهم الإشارات غير اللفظية المتكاملة لكل مشارك.

ملخص عن التركيبة السكانية للمشاركين (العمر والجنس والجنسية والموقع والحالة الاجتماعية). تراوحت الخبرة العملية للمشاركين من أقل من ثلاث سنوات إلى أكثر من 15 عامًا. أعراقهم هم بحرينيون (ن = 10) وهنديون (ن = 5). ومن بين المشاركين الخمسة عشر كان أحدهم ممرضًا. كان للمشاركين مناصب مختلفة ، لكن معظمهم كانوا ممرضات متخصصات (ن = 10).

عرضت البيانات التي تم تحليلها تجربة الممرضات المشاركات ، والتي تم جمعها وتصنيفها وفقًا للتحليل الموضوعي. (Braun & Clarke 2006) الموضوعات والمواضيع الفرعية التي ظهرت أثناء تحليل البيانات. تم توحيد المفاهيم المترابطة تحت ثلاثة محاور أساسية وثمانية مواضيع فرعية. ظهرت ثلاثة مواضيع رئيسية من التحليل الموضوعي: (1) مشاعر مرهقة مقابل مشاعر مقدرة ومكافأة. (2) العوامل المؤثرة على الرعاية التمريضية ؛ (3) الضيق و العسر الأخلاقي.

تم الإبلاغ عن مصداقية البيانات التي من خلال اعتماد نموذج لينكولن وجوبا لعام 1985 ، حيث طورت أربعة معايير جودة لموثوقية البحث النوعي: المصداقية والاعتمادية والتأكيد وقابلية النقل لضمان صحة البيانات وإمكانية نقلها إلى إعدادات أخرى.

ظل توفير الرعاية التمريضية وخبراتهم في أماكن الرعاية المتعددة يمثل تحديا، ويرجع ذلك جزئيا إلى خصائص المرضى والأسر والعاملين في مجال الرعاية الصحية والعوامل التنظيمية مثل نقص التدريب أو البرامج التعليمية أو حتى السياسة الداعمة.

تعكس رعاية نهاية العمر في مملكة البحرين وتتأثر بالرعاية التمريضية الشاملة الأساسية. أبلغ ممرضو الأورام عن معاناتهم ولكنهم استفادوا أيضا من تجاربهم. هناك حاجة إلى تدريب رعاية مرضى السرطان في نهاية العمر ويتم حثه من قبل ممرضى الأورام ، خاصة لمن هم أصغر سنا وأقل خبرة. أيضا ، تم تكليف الدراسات المستقبلية لاستكشاف التدخلات للمساعدة في التغلب على التحديات التي تعيق الممرضات عن تقديم رعاية عالية الجودة للمرضى المصابين بأمراض عضال في مملكة البحرين.

خلاصة

يعد دور ممرضوا الأورام أساسى في الرعاية التلطيفية لمرضى السرطان ، خاصة في مراحل نهاية العمر. إن رعاية مرضى السرطان الميؤوس من شفائهم أمر مرهق ، مصحوبا بمشاعر سلبية وإيجابية ، لكن ممرضى الأورام يتحملون مسؤولية لا مفر منها. ومع ذلك ، لا يعرف الكثير عن هذه التجربة لمرضى الأورام في مملكة البحرين في رعاية مرضى السرطان المصابين بأمراض عضال في الأيام أو الأسابيع الأخيرة من حياتهم. هدفت هذه الدراسة إلى استكشاف تجربة ممرضى طب الأورام في تقديم الرعاية للمرضى الميؤوس من شفائهم في مملكة البحرين ، كما هدف البحث الاجابة على عدة أسئلة لتفي الهدف الأساسى من هذه الدراسة: (أ) ما هي خبرة ممرضى الأورام في تقديم الرعاية للمرضى الميؤوس من شفائهم؟ و (ب) كيف تؤثر تجربة ممرضى الأورام في تقديم الرعاية للمرضى الميؤوس من شفائهم على جودة الرعاية المقدمة للمرضى؟

تم استخدام تصميم بحثى استكشافى وصفى نوعى لهذه الدراسة لاستكشاف تجربة ممرضى الأورام مع المرضى الميؤوس من شفائهم ، والتي أجريت في مستشفيات في مجمع السلمانية الطبى (للمرضى الداخلىين والخارجيين) في قسم الأورام. كما تم جمع البيانات باستخدام أخذ عينات هادفة لتشمل خمسة عشر ممرضا من قسم الأورام الذين كانت خبراتهم تتضمن خصائص مختلفة مع أدوار ومؤهلات مهنية. كذلك تم جمع البيانات من خلال إجراء خمسة عشر مقابلة شبه منظمة مسترشدة ببروتوكول مقابلة شبه منظم. بينما تم تحليل البيانات باستخدام نموذج التحليل الموضوعى لـ Braun and Clarke لعام 2006 دون ذريعة. كشفت نتائج البحث عن ثلاثة محاور رئيسية انبثقت من التحليل الموضوعى: (1) الإرهاق مقابل مكافأة المشاعر. (2) العوامل المؤثرة على الرعاية التمريضية ؛ (3) الضيق الأخلاقى.

كانت خلاصة الدراسة تعكس رعاية نهاية العمر في مملكة البحرين والتي تتأثر بالرعاية التمريضية الإجمالية الأولية. أبلغ ممرضو الأورام عن معاناتهم ولكنهم استفادوا أيضا من تجاربهم. هناك حاجة إلى تدريب رعاية مرضى السرطان في نهاية العمر ويتم حثه من قبل ممرضى الأورام ، وخاصة الأصغر سنا والأقل خبرة. أيضا ، أوصت هذه الدراسة لتوجيه الدراسات المستقبلية لاستكشاف التدخلات للمساعدة في التغلب على التحديات التي تعيق الممرضون عن تقديم رعاية عالية الجودة للمرضى الذين يعانون من أمراض عضال في مملكة البحرين.

الكلمات المفتاحية: مريض على وشك الموت؛ رعاية نهاية العمر؛ الرعاية التلطيفية؛ ممرضون الأورام.